HEALTH CARE REFORM LEGISLATION: ECONOMIC IMPLICATIONS FOR RURAL SMALL BUSINESSES AND THE RURAL ECONOMY

HEARING

BEFORE THE

SUBCOMMITTEE ON THE DEVELOPMENT OF RURAL ENTERPRISES, EXPORTS, AND THE ENVIRONMENT

OF THE

COMMITTEE ON SMALL BUSINESS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

WASHINGTON, DC, JULY 28, 1994

Printed for the use of the Committee on Small Business

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HEALTH CARE REFORM LEGISLATION: ECONOMIC IMPLICATIONS FOR RURAL SMALL BUSINESSES AND THE RURAL ECONOMY

THURSDAY, JULY 28, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE DEVELOPMENT OF RURAL ENTERPRISES, EXPORTS, AND THE ENVIRONMENT,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2359–A, Rayburn House Office Building, Hon. Glenn Poshard (chairman of the subcommittee) presiding.

Chairman POSHARD. The Subcommittee on Rural Enterprises, Exports and the Environment will come to order. Today's hearing will examine the economic implications of health care reform legislation for rural small businesses and the rural economy.

In our first meeting we asked the folks who are with us today to come back when they had completed their examination of the various health care bills that are before the Congress and to help us better understand the economic impact of those bills on the rural economy today. That is what this hearing will be about.

The debate has entered into a crucial stage here on Capitol Hill and across the country. One result of arriving at that stage is the current efforts of the majority leadership here in the House to craft a new bill that can pass and that can achieve the President's major reform goals: Universal coverage and cost containment.

As rural advocates, many of us have felt in recent months that we have had some significant success. We have included provisions important to rural America in the reform bills that have moved through the various committees. Now, as it appears that a new bill is emerging and likely will be the bill that the House will finally consider, we feel it is necessary to maintain our profile as advocates for rural communities.

It is important to remind our colleagues that the special conditions and problems of rural communities will require certain special provisions. Rural communities stand to gain a great deal from the reform of the country's health care system, especially from reform that does deliver on the promise of universal coverage. Rural communities might even benefit relatively more from reform than other communities if reform is done properly.

But the way we do reform could also pose new threats to the rural communities and their health care delivery systems. We will hear about both the threats and the opportunities today.

This hearing follows one that the subcommittee conducted on June 23. As I mentioned, a bill has been introduced by Representatives Stenholm and Roberts, of which I am an original cosponsor. A number of important provisions of that bill were included in H.R. 3600, the Ways and Means Committee bill, and some of us are working to see if we can get those provisions included in this new majority bill.

Today, we will focus on findings of analysis carried out by the Rural Policy Research Institute on health care reform and the rural economy. The academic experts that RUPRI has assembled through its research panels have made invaluable contributions to the health care debate already this year. RUPRI analysis and recommendations were the basis of much of the bipartisan rural bill I mentioned earlier, and RUPRI economists provided important testimony at our first hearing, as they have before other committees around the hill.

RUPRI economists conducted a very interesting and useful briefing in the Cannon Building just last week for our rural health care caucus and rural caucus members.

I point out that this is an independent collection of economists, and I believe a range of ideological views have been taken into account in the consensus documents that you folks have produced. We appreciate that. I think your reports show that you are purely nonpartisan.

Of course, we are interested today in RUPRI's most recent analysis found in this document that our Members each have a copy of now, and we are particularly interested in the implications of their findings for the still-evolving proposal that we in the House will soon consider.

If I can steal our witness's thunder to make one point, it is this: RUPRI economists believe that health care reform done properly, I think—and we will get into this in some discussion—with universal coverage, will benefit rural America's economy, will benefit its health delivery system and will, on the whole, benefit rural small firms.

I hope our hearing can clarify how rural America is faring so far in the legislative process. I hope the testimony can help explain how the still-changing reform proposals will likely affect rural communities. I hope the hearing can help us determine what are the important next steps for rural advocates.

The subcommittee knows Mr. Fluharty, who is director of RUPRI and who is based at the University of Missouri, and we are very happy to have him here today. We want to welcome Dr. McBride of the University of Missouri and Dr. Mueller, who is director of the Nebraska Center for Rural Health Research.

I am very pleased that we have both the RUPRI expert panels represented here today—the economics panel and the health delivery system panel.

We thank you for coming, and I will turn now to my colleague, Mr. Hefley for any opening statement.

[Chairman Poshard's statement may be found in the appendix.]

Mr. HEFLEY. Thank you, Mr. Chairman.

I appreciated your opening statement. You point out one factor that I think we should take note of; the bipartisan rural health

care bill. I think that is very important, that that be a bipartisan bill. We made that point when we had the hearings on it here the other day.

Then you mentioned the Majority Leadership bill, which is being drafted in both the House and the Senate right now, which is being done in secret, has no Republican participation whatsoever, probably will get no Republican support whatsoever, while the leadership on the Republican side of the aisle has been pleading with the majority to let's sit down and try to work this out in a bipartisan way.

It is a sad commentary I think on our process when we are dealing with something as important as this is that it has to be done that way and that there is a crisis attitude not because of a crisis in health care but a crisis that the election is coming up and we cannot go to the voters without a health care bill. I think that is rather sad.

But I am glad we are here today, and I think the efforts to reform the health care system is moving, as the Chairman says, into a crucial stage. I share his concerns that rural health care issues should receive more attention, though perhaps not for the same reasons.

I see our rural areas as the first test, kind of the canary in the coal mine, if you will, of health care reform success. I say that for two reasons:

First, rural areas are always hardest hit by government mandates, whether its be minimum wage, Davis-Bacon requirements, other Federal laws which raise the cost of labor and retard rural economic development. For some advocates of these laws, you could argue that that was the intended purpose, to protect high-cost labor against competition from low-cost labor. But whether it was their purpose or not it seems to be the result.

I suspect employer mandates will have the same kind of result. Areas with low costs and labor-intensive jobs—rural areas, in other words—will shoulder a large portion of the burden. Employers in those areas do not have the resources necessary to cope with another wage tax and employees will be laid off. I suggest that having health insurance is small consolation for someone without food on their table and a roof over their head.

Second, rural health care problems pose the greatest hurdle to health care reform. Rural areas have large populations of uninsured low-income people. If we are going to live up to the President's promise of universal coverage, we need to solve health care that is facing the rural areas.

In that respect, I have before me a study conducted by the National Center for Policy Analysis conducted in 1991 which looks at rural health care availability around the world. One conclusion I draw from that study is that rural health care concerns are universal. The problems facing my constituents in eastern Colorado are similar to those experienced in northern Canada or along the Rhine in Germany: Limited access, no specialists, poor equipment and on and on.

The other conclusion I draw is that national health care is no solution to rural health care problems. Consider the following findings:

People living in British Columbia's two largest cities receive 55 percent more specialist services per capita than rural residents. British Columbia's urban residents are 5½ times more likely to receive services from a thoracic surgeon, 3½ times more likely to see a psychiatrist, 2½ times more likely to receive services from a dermatologist, anesthesiologist or a plastic surgeon.

After 40 years of national health care, people in rural England still have to travel to urban areas to access CAT scans and other modern medical technology.

In Norway, residents of Oslo are 15 times more likely to see a specialist than people living in the northern part of the country.

In Brazil's free health care system, urban residents see doctors nine times more often than rural residents.

Venezuela promises free health care to everyone, but all of Venezuela's free health care clinics are located in large cities.

In Mexico, where free health care is a constitutional right, 85 percent of the health care resources are consumed by 35 percent of the population, mostly residing in large cities.

In other words, universal access is a myth. You can promise it, but you cannot deliver it. Worse, government intervention in these countries has reduced the quality of the care their citizens receive. Consider that both Canada and England have severely limited the access to such lifesaving procedures as open heart surgery and brain scans.

In conclusion, let us not lose sight of the forest for the trees. People living in rural areas—by definition—have less access to most of the services we take for granted in urban areas, including health care. If they had the same access they would not be living in rural areas. They make this decision when they move to those rural areas.

This fact of rural life poses special problems that we need to tackle in order to ensure health care availability for our rural population. For the reasons I stated above, however, increasing the role of government in our health care system I firmly believe is not the solution.

To the contrary, I think the report is clear that excessive government involvement exacerbates those problems, lowering access to care while reducing its quality. To suggest otherwise is to ignore the experiences of Canada, England and other countries that have experimented with national health care.

Once again, I would thank the Chairman for holding this hearing, and I look forward to the testimony of the panel.

Chairman POSHARD. I wish the minority leader on the committee felt a little more strongly about his position.

Thank you, Mr. Hefley.

[Mr. Hefley's statement may be found in the appendix.]

Chairman POSHARD. Well, Mr. Fluharty, we shall begin with you. We are going to allow all three of you to make your presentation in whatever fashion you deem appropriate, and then, hopefully, we will be able to give you a lot of questions to answer for us.

TESTIMONY OF CHARLES FLUHARTY, DIRECTOR, RURAL POLICY RESEARCH INSTITUTE (RUPRI), UNIVERSITY OF MISSOURI

Mr. FLUHARTY. Thank you. Thank you, Mr. Chairman, Mr. Hefley. I appreciate the opportunity to be with you today.

I would like to make several comments in response to your two presentations, and what we would like to do is have a brief comment representing each panel and then go immediately into questions, if we could.

Chairman POSHARD. Chuck, you might want to pull that a little closer to you. It is a little far away.

Mr. FLUHARTY. The intent of the RUPRI health panels are to create a national expert panel group that could be a decision support vehicle for Congress as health care is designed, implemented and evaluated. RUPRI has worked extremely hard to make this a bipartisan panel; in each case a panel that represents geographic diversity, sector diversity and diversity of health sector interest.

It has been interesting watching the economics panel work. It, indeed, is a bipartisan panel. Watching their first 5 days of discussion regarding these rural health economics questions was indeed unique, and a rewarding personal experience for them professionally. We have worked very hard to attain these results, and we hope they are helpful to this subcommittee.

The membership of those panels are listed at the back of your testimony, Mr. Chairman, if you would like to explore in more detail who they are.

Today, Dr. Keith Mueller will give a brief overview of the delivery panel's consensus and talk briefly about where this group is now headed, in terms of the main bills that are coming before you, as we know it at this time. Then Dr. Tim McBride will discuss consensus from the economics panel which is contained in the document in front of you. We would like to allow the rest of our time for questions and answers.

I would like to make three very pertinent overview comments. In summary analysis of this kind, it is critical to understanding what it does not accomplish, and its limitations.

The first limitation I would mention is we had to look at bills on the assumption they would be enacted as implemented. You both have raised a very serious question. First of all, the possibility for national health reform to have a very positive impact on rural America is extremely great. Conversely, the possibility for health reform to have massive negative impact on rural America is also very great.

The key congressional concern on this issue should be to make certain that these proposals are understood in their totality in the next month and that the transition impacts are equally understood. Because in that transition period the fragility of rural businesses, rural health care and, frankly, rural families working in small businesses are most at risk. It is this transition period that both RUPRI panels feel is very critical in this legislation.

We intend for each panel, as soon as final bills are passed by each house, to provide the same thorough, objective analysis that we have sought to do on the bills in front of you, and we want you

to be aware that we will try to do this work as expeditiously as possible, when bills become finalized.

At this point I would ask Dr. Mueller to begin, then Dr. McBride, and we will try to allow most of our time for questions.

TESTIMONY OF KEITH MUELLER, DIRECTOR, NEBRASKA CENTER FOR RURAL HEALTH RESEARCH, UNIVERSITY OF NEBRASKA MEDICAL CENTER

Mr. MUELLER. Thank you, Chuck, Mr. Chairman and Mr. Hefley.

You have in your written record a full report of six critical issues that the delivery panel has identified over the last 10 months and has focused on in its deliberations, along with what we have identified as key concerns and some specific legislative remedies for those concerns.

Today, what I will do is give you an even more focused backdrop for our ensuing dialogue that we will have this afternoon by looking at four summary areas of concern that need attention as legislation moves forward. As I speak to these I am speaking from the base of examining the committee marks that have come through the House as well as one in the Senate.

The first of those four areas is securing providers for rural communities, and really this has two parts: Facilities and professionals.

On the facilities side, as we examine provisions related to essential facilities in rural areas, we need to be careful how we define what are essential facilities, and we ought to be relying on State and local designation of those facilities. If there is one thing we know about rural across the board it is that one size or one model does not fit all. So, we need to have a broad definition legislatively with discretion at State and local.

On the professional side, when we examine issues of health work force and physician training, it is important to increase the supply of primary care physicians, but for rural it is much more important to pay attention to programs that would enhance or improve the distribution of physicians as opposed to merely increasing the supply. So, we need to watch work force planning issues with distribution of physicians in mind.

Similarly, we also need to pay attention to supply and distribution of nonphysician primary care providers, nurse practitioners, physicians' assistants.

Finally, under securing providers, one area that has received perhaps too little attention in legislative deliberation is an array of other providers that are critical for rural areas. Let me focus on two types here: One, providers who can pay attention to the mental health needs of rural citizens—this would be social workers, clinical psychologists—and, second, providers trained adequately to deal with issues in geriatric care for the elderly that we know represent a disproportionate share of rural.

The second major area that I would bring to you this afternoon is building and sustaining rural delivery systems. I think Congressman Hefley is right, that if you do not have a system out there for rural citizens to access, providing them with financial coverage is of limited value, at best.

Such systems ought to be locally based. They ought not be designed and implemented from government levels above the local areas. Indeed, local citizens ought to be involved in designing health care systems for their own purposes. They will need medical assistance and medical services from outside their areas.

That does not mean the system cannot be designed with local interest in mind. Systems ought to be integrated and coordinated in accordance with logical patterns of medical utilization, not some arbitrary definition of alliance according to geopolitical lines but rather service areas that local people, again, are involved in defining.

Finally, under building and sustaining systems, payment needs to be set at appropriate levels. We have paid attention and Members of Congress are to be congratulated in recent years for watching for urban rural payment equity under public payment programs. If we are going to expand payment programs, we need to stay on top of rural urban equity. We also need to be sure that any level of care that remains uncompensated is somehow reimbursed back to the providers. This will be one of the more critical transitional issues if we transition from something short of universal coverage to something approximating universal coverage.

In the interim, there will remain some unpaid patients in the fragile rural health care delivery system. That is a critical issue.

And, finally, under payment, payment should cover the services rural citizens need, and those relate back to issues like services for the elderly, services for those with mental health problems.

Third major area, in any decisions involving governance of a new system or involving issues like setting quality of care standards, rural interests need and must have representation in those decisions so that they are made, for example, on quality of care standards, with rural care delivery in mind.

In fact, if you take some of the statistics that Congressman Hefley mentioned earlier, those disparities may mean that services ought to be used less in urban areas as well as being used more in rural. If we had rural interests represented in developing guidelines and clinical standards, that might be a result favorable for all.

Finally, the fourth area is developing some kind of reporting mechanism that would enable Members of Congress to understand better how a variety of programs and funding mechanisms for rural citizens and rural delivery systems work, how well they are coordinated.

If you look at grants for systems development, rural transition grants, emergency services, telecommunications, payment bonuses for physicians, does the total mosaic really make sense for rural areas? We believe that that is best accomplished if Congress were to create something along the lines of a rural commission that reports to Congress progress being made in meeting the health care needs of rural citizens through either reform legislation or, more broadly, through all of these programs so that you have a better sense of what is happening.

Those are the four areas that represent the six critical issues of the delivery system panel.

TESTIMONY OF TIM MCBRIDE, ASSISTANT PROFESSOR OF ECONOMICS, PUBLIC POLICY AND GERONTOLOGY, UNIVERSITY OF MISSOURI

Mr. MCBRIDE. Thank you, Mr. Chairman, Mr. Hefley, for inviting me here today on behalf of the Rural Health Economics Expert Panel. It is a pleasure to testify here.

As the Chairman knows, our Rural Health Economics Expert Panel completed the briefing document you referred to last week, and so my testimony here is based on that document.

The briefing document provides the panel's initial analysis of the impacts of reform on rural areas, and although our panel has been working hard to develop these consensus opinions, I would emphasize that they are preliminary. Because the health care sector is immense, changes of this magnitude being discussed are going to have profound impacts on the rural economy.

Our panel has not had sufficient time, we feel, to investigate all these implications, but we are engaged in ongoing analysis, and we are here today to provide you with some consensus opinions.

Mr. Chairman, I appear here today as a representative of the 11-member expert panel, and, wherever possible, I will try to provide you with the consensus opinions of the panel. But if you delve into an area we have not discussed I will inform you of that and provide you with my own opinions, if that is acceptable.

In developing the analysis, the panel studied three major health care proposals on the assumption that they would be enacted as introduced. These bills were enacted with specific attention on the economic impact of each proposal on four areas of the rural economy: Rural health care business, other rural businesses, rural families, and rural local governments.

Now, while the analysis contained in this document is rather extensive, several general panel consensus opinions would serve well to focus today's discussion I think. First and foremost, I think we concluded that health care reform would have a positive impact on the economic status of rural areas, assuming key conditions are met.

Now, this conclusion we based primarily on the special characteristics of rural areas. For example, rural areas tend to have higher proportions of elderly people, people working for small businesses, self-employed individuals, relatively low-wage jobs and employers purchasing insurance without employer assistance, to provide a few examples.

The three legislative proposals we analyzed to date contain some provisions that will harm some of these groups. However, on balance, we feel that the proposed legislation contains enough provisions to aid these individuals that led to our conclusion about the benefits of health care reform for rural areas.

We are convinced that the major benefits of these proposals stem from these impacts. So, it is important that Congress think carefully about these groups as it proceeds.

Now despite our panel's conclusions about the benefits of health care reform for rural areas, our panel has raised a number of significant concerns. First, we are concerned about the viability of the rural economy in the transition period. The economic status of many rural businesses, families and governmental bodies is fragile.

Our panel urges that lawmakers think carefully about the transition provisions with a special focus on their impacts on rural institutions.

Second, our analysis and conclusions regarding these positive health care reform impacts on the rural economy are based on the full provisions of the three bills as considered. Changes in the legislation or incremental adoption could have serious negative consequences if they are not carefully thought out.

And, finally, the panel's positive consensus opinion about the impacts of health care reform legislation is based largely on provisions that expand access to health care for rural Americans. In particular, we feel that universal coverage would be particularly beneficial to rural areas and that many of the positive impacts of health care reform may not be realized if the legislation does not eventually lead to universal coverage.

Our panel has enumerated a number of other more specific concerns that I would be pleased to discuss in more detail here. We hope this briefing document and testimony will be helpful in considering the impacts of reform on rural areas, and I thank the committee for inviting me here today.

Chairman POSHARD. Thank you Mr. McBride, Dr. Mueller, Mr. Fluharty, for your testimony.

[Mr. Fluharty's statement may be found in the appendix.]

[Mr. McBride's statement may be found in the appendix.]

[Mr. Mueller's statement may be found in the appendix.]

Chairman POSHARD. Joel, if it is OK with you, let us just kind of have an open discussion here rather than going back and forth formally.

If we can talk to you about your study. Frankly, I don't know what to do at this point in time about health care reform. We have so many bills running around here right now and so many so-called compromises and so many issues, I don't think anybody is more than 55 percent sure in their soul what the right thing is, but we need to talk about it.

Now, Dr. Mueller, I was interested in your statement about building from the bottom up with respect to service delivery and health care in rural areas. I would assume by that statement that you have some real reservations about the President's plan with respect to the creation of the alliance structure, the regional alliance structure being implemented from Washington down?

Mr. MUELLER. Well, certainly if that is the way it was ultimately implemented, yes. That if you are creating some sort of a regional group, whether you create a mandatory alliance or a voluntary purchasing cooperative, it ought to be locally based. Its membership, if you are going to specify that legislatively in terms of who would be elected to a board of such a group, should be consumer based and should be local consumer based.

Even going so far as to say that if it is a large geographic area that you end up with, because you need that for a minimum population base for pooling people together, that the representation on a governing board of that large area, even if it is a voluntary board, ought to be geographically based as well so you do not have a situation in which, say, several communities ranging between 30,000 and 50,000 dominate the decisions so that the large providers in

those communities are the ones that sort of take their care out to the rural community.

What we are advocating is setting up the decisionmaking so that the rural community might end up with the same general surgeon coming out once a week, but it was their decision, saying, OK, this is the way we want to do it. We want to work with that hospitals to bring the physician out.

If you flip that around, you have two dangers. The first one is you have a system that is being imposed, and that is not often or not always workable. The second is you would have a system that would be resisted locally.

If there is one thing that I can speak confidently based on my own personal experience working with rural communities, if you try to impose something on them, they will resist it.

Chairman POSHARD. Very independent attitude, yes.

Mr. MUELLER. Much better if you—you may end up at the same end point, but you should start from having them involved.

Chairman POSHARD. Let me ask you and Dr. McBride—this has as much to do with economics as it does with service delivery mechanisms. Do we even need to be dealing with any sort of change in the delivery structure itself with respect to delivering an economy of scale for services in health care? Does our present system perform that adequately enough? I don't know. Do you have an opinion on that? I know your study did not take that into consideration, but do we need to fundamentally change the way we deliver health care in rural America today?

Mr. FLUHARTY. The baseline for the delivery panel—since each analysis begins with assumptions—was the continuation of the existing rural health delivery trend. I suggest we start with the baseline assumptions that the delivery panel used and ask Keith to start, since they did grapple at length with how do to get at that issue.

Mr. MUELLER. In terms of how care is delivered on an individual basis, the answer is probably no. But in terms of how care is organized and delivered in a community or in an area of a State, for example taking your State or mine, Illinois or Nebraska, and we look at some rural areas that are more sparsely populated, the answer is yes.

We do know that the number of facilities that we once thought were appropriate are no longer appropriate. We do not need as many per se of the same type of facility—I am thinking, obviously, of small rural hospitals. Does not mean we do not need care in the communities where the small rural hospitals have always existed, at least since the Hill-Burton days of the 1940's, but it does mean perhaps we should change that delivery mode so that instead of it being a full service hospital it is now a clinic of some kind in that community.

It also means instead of thinking of having a primary care physician as a solo practitioner in a rural community, we need to be thinking about three or four rural communities pooling their resources and hiring two or three primary care physicians so that they can spell each other and not be on call 24 hours a day.

The kinds of environments our health care professionals have come to expect coming out of medical schools are very different

than they were when some of these delivery systems were designed.

So for the sake of the future of the delivery system and being sure it stays in place, the answer is yes. That is even without thinking of it in any kind of economic efficiency model. This is thinking of just sustaining an adequate delivery system to get from here to being confident we can do that. Yes, we would have to change our thinking a bit about what that entails.

Chairman POSHARD. Will any of that which Dr. Mueller just suggested have an economic impact, positive or negative, on the rural economy, Dr. McBride? Is it possible for you to venture an opinion on that?

Mr. MCBRIDE. Well, again, as you noted, our panel did not deal with that issue directly, so part of this is my own extrapolation of what our panel discussed. We dealt with those issues in a peripheral sense. I think our panel operates somewhat with the other panels, so that we take what they say and then work off of it, and so I think it would matter quite a bit.

We did have a lot of discussion about the impacts of the current trends in health care in general in urban and rural areas—for example, toward managed care and primary care providers and how that would impact cost containment and the access to care in rural areas. So, I think those are definitely relevant.

We did not really come down with any consensus opinions about changing the delivery system. Our issue as economists is more on the financing system, as you know. So, I think the delivery issues did not come up that much, other than the typical economist worries about excess demand and excess supply that might come out of—as a follow on from health care reform, and we were concerned about some of those issues.

Chairman POSHARD. Joel, do you want to follow up on any of this before we break? We are going to have to break for a vote for about 3 minutes.

Mr. HEFLEY. For the vote.

Let me ask you one quick question before we go.

You considered these three approaches, the three bills. The Clinton bill, in my estimation, is essentially dead. The Ways and Means bill is not going to pass. Something crazy might pass the House, but it is not going the pass the system. The leadership bills are probably not going to get enough votes to pass the whole system.

So did you consider anything else, like the Rowland bill, for instance? Did you take those into consideration?

Mr. FLUHARTY. Let me talk briefly about how we did try to get at what we might do and remain bipartisan.

As you know, this sort of panel work is fairly costly, and we have operated on a rather small-scale budget for this project with all of the experts serving essentially at the pleasure of their universities.

To minimize costs and maximize efficiencies the economics panel sought to address the core approaches discussed at this point in the debate, and decided the most centrally discussed different approaches were the Clinton, Chafee and Cooper packages. We simply tried to leverage the most useful analyses we could initially develop.

The health delivery panel tried use the existing bills introduced working with staff in a bipartisan way to try to identify packages that we thought could at least get at several consensus approaches that might be helpful to Members. Obviously, it is a difficult call, because there are a number of good packages with good components that we did not have a chance to analyze.

What we tried to do is get as many central components as we could, Mr. Hefley, given our time and resource constraints. As you know, it is a rather mammoth undertaking in an experts' panel like this. There are a few approaches that we probably did miss, and on the economics side it is even more difficult because there is such a variance regarding approaches and alternative analyses.

But, that is essentially how we tried to do it.

Mr. HEFLEY. Like to follow up on this, but we have had our second bell, so I suspect we better——

Chairman POSHARD. We will go on for the vote and then we will come back for further questions. I think Congressman Stenholm is going to be joining us when we come back.

Mr. FLUHARTY. OK, thank you.

Chairman POSHARD. Thank you.

[Recess.]

Chairman POSHARD. We will get started again. I think Mr. Hefley is on his way over. We apologize. We had two votes in a row so we had to wait around. We don't usually have to take a break that long.

Let me get back to some questions, and, again, you will have to advise me if these are not within the parameters of what you studied. If they are not, if you can give me some sense of where you are on them, I would appreciate it.

I think there is a lot of talk right now, and especially in some of the meetings I have attended recently, about the different aspects of reform as they relate to each other. I think changing one element has consequences for the other elements in the reform and so on, and I want to try to clarify this by looking at the three elements of reform—the universal coverage, the cost containment and the employer mandate—and try to apply these to rural circumstance, if you can.

If you start out with a basic RUPRI premise, and that is—at least I think it is—a premise that, as I read through the study, that achieving universal coverage is essential to the potential benefits for rural communities, I assume that that means not just an expanding coverage therefore leads to a healthier, more productive work force but that actual direct economic benefits accrue to rural communities, to ordinary businesses and to the health sector part of the rural economy.

Now, how does universal coverage do that?

Let me say before you answer that we are joined by Congressman Stenholm from Texas, who has the bill which we have already had one hearing on. Congressman Stenholm, thanks for joining us, we are just having an open discussion here so you can open up your mike and jump in any time you please.

OK, the question here, for Charlie, since he just arrived, is: We have asked the panel how does universal coverage essentially benefit rural communities in terms of the economic benefits?

Mr. MCBRIDE. I will take that question, I guess.

You are right about your consensus opinion that we arrived at that opinion, and I think you are right in saying that universal coverage is on sort of a continuum over expanded coverage. We felt that the universal coverage has a benefit because, in general, it would increase economic activity in rural areas, and it has a number of benefits that sort of trickle down throughout rural areas. It reduces the uncompensated care burden on rural hospitals and providers, and that is a key characteristic that we looked at.

We also felt that it would increase the demand for health care services, and it is important to keep in mind and we split it out this way, that health care is a business. It is important to keep that in mind. So, the things that help health care providers tend to help rural health care business and rural business in general. So, that was an important component. So, that provides a boost to the rural economy.

Also, in general, we returned back to the—one of the elements we looked at, which is the special characteristics of rural areas, the larger number of lower income persons, small business workers and workers in different industrial sectors that you do not see in urban areas and more self-employed workers. To the extent that reform can be written with those persons in mind and with subsidies and structures that might help them, then it might tend to give an added extra boost to rural areas.

The key thing is if you use any funding from—one other key aspect I would mention to you, and you can elaborate if you wish, is if you use any funding for Medicare and Medicaid cuts to fund the rest of the program, then I think you need to offset that in some other way through expanding use. So, it is key to universal coverage—we felt that was key toward offsetting the effects of the Medicare and Medicaid cuts which were used for low-income subsidies, for example.

Chairman POSHARD. So, for example, in the President's bill, where you are attempting to achieve universal coverage and yet you are cutting Medicare benefits—I don't remember the precise figure——

Mr. MCBRIDE. $124 billion.

Chairman POSHARD [continuing]. $124 billion, a lot of which accrues to the rural hospitals because of the 75 or 80 percent of Medicare or Medicaid patient load that they carry. Considering the Medicare cuts or slowdown in increases, whatever you want to term them, and the increased economic activity as a result of having more people come into the health care system with total universal coverage, on balance, is that positive or negative?

Mr. MCBRIDE. These are the key words that we kept on coming back to—is on balance. Because you are definitely right when you look at the specific provisions of the Medicare and Medicaid cuts. Our panel has real concerns about the impacts of that on rural areas and rural health care providers as a business.

But we also saw that there were provisions in the President's bill, for example, that increased spending in other areas that would help Medicare benefit shares, specifically the home health care program and the prescription drug coverage program, which would tend to offset the cuts in Medicare and Medicaid.

So while there are specific provisions like the Medicare-medicaid kits which have disproportionately negative impacts on rural areas, there are other provisions that would help rural areas, and that is the—on balance is the key.

Mr. FLUHARTY. Two additional comments, and then I think Dr. Mueller might comment.

At the hub of the issue, if incrementalism obtains, we are at risk of having the consensus of this panel change. That is the key again. In that bill, we are looking at a total package.

So those questions about elements being pulled in and out, Medicare is an excellent example, and I think Keith may want to speak to that. That is the point I say make regarding study limitations. As we begin the legislative alterations that panel consensus could definitely change overnight, if one of those key elements is extracted from the final legislation, because of that rural fragility.

Keith?

Mr. MUELLER. From a financial point of view, even from the delivery system panel's perspective, the key element is the bottom line, if you will. What does it mean, ultimately, for the rural physician, the rural hospital, the rural clinic if, on the one hand, you are reducing their expected revenue, to use that phraseology, but, on the other hand, are increasing their revenue from other sources, be it universal coverage—which both panels have said is one of the key elements here—or if it is through other programs of special assistance for classifications of providers, Medicare-dependent hospitals assistance or rural transition assistance, so that what used to be a hospital can now become something else, have fewer expenses, which means that if you lower their revenue that is OK because they have balanced it with lower expenses.

It is critical that all of that be considered as a package. If we are, as Chuck said, going to move incrementally toward some ultimate goal or objective, we have to be very careful how we time the various activities. If we time it that cuts precede some of these offsets, rural providers that are currently very much on the brink and very fragile economically will be gone before we have universal access.

And, again going back to our earlier points, the universal financial access is of limited value then.

Chairman POSHARD. If anyone wants to join in on this discussion, feel free to do so.

Mr. STENHOLM. Mr. Chairman.

Chairman POSHARD. Yes, sir.

Mr. STENHOLM. I would just like to ask a couple of questions.

Of all of the bills that you have analyzed and all of the proposals that are out there right now, today, what are the characteristics that you think are a must from a rural person that need to be included in any final bill? And then the reverse of that. What are the things in the various bills, if there are any, that ring warning bells for rural communities in the various bills?

Mr. FLUHARTY. Why don't you start.

Mr. MUELLER. I will start with at least two or three, and then Dr. McBride can add some, if he would like.

One that immediately comes to mind is programs designed to improve physical access not financial access to health care. That if we are talking about universal coverage with the objective of better

health care services and more available health care services for rural citizens, any reform bill should speak to that very directly, with assistance designed to improve the availability of care in rural areas. That can be done with network development assistance. It can be done with capital assistance. It does not take a lot of money on the capital side so that facilities can be converted and made more suitable for today's mode of health care delivery.

A second issue of major concern, one that I raised earlier, is the distribution of medical care providers, that that needs to be addressed in health care reform. I would reiterate what I said before because it is an important distinction. We do not mean merely increasing the supply of primary care providers, we mean programs designed to distribute primary care providers more equitably so that rural residents have access to their services.

Those are provisions that ought to be built into any kind of work force planning that goes on as part of reform legislation. Not just tax incentives to go practice in a rural area but programs, for example, tied to GME and IME going to programs that have a track record of producing physicians that, in turn, practice in rural areas, programs that recruit medical care providers out of rural communities. I think that is a secondary of absolute essential service for rural.

The third that I would mention is rural representation in any kind of governing boards and mechanisms that are put in place as part of health care reform. As I said earlier, I would include in that efforts to look at quality of care and development of quality standards that ought to include rural as well.

The final one I would close on would be a mechanism that Congress would design so that you get a better sense as we move out into years three, four and five of how this is working in rural areas and how rural citizens are benefiting.

As the delivery system panel has thought about this we have recommended a committee or commission that reports directly to Congress that can give you reports back on how the total package of programs you put in place works for rural citizens.

Mr. MCBRIDE. I will emphasize one other one that Keith mentioned, because it was crucial to our conclusions, and that is the physical capacity provisions, because that was crucial to the finding that health care reform could help health care as a business. So, I will just emphasize that one from an economic standpoint.

One of the big issues we focused on second was transition provisions. It is key that you focus in on those and that the transition provisions be written in such a way that the rural needs be taken into account.

One example was the one we just talked about in making sure that the Medicare cuts, the timing of those, is not disproportionately harming rural areas and so that the Medicare cuts do not precede the other programs that are put into place that might help health care providers.

Crucial, I think, is the subsidies and other benefits that are put in, again, focusing in on the special characteristics of rural persons. Without subsidies directed at lower income persons, workers for small businesses, people in particular sectors, industrial sectors, self-employed, those are all characteristics of rural persons dis-

proportionately, and you need to make sure those are in there to take care of rural areas.

I think one issue that we ended up talking a bit about was the whole issue of how the boundaries are set for the health alliances and for the way that community rating premiums are set.

There is a lot of worry among the economists in that if you do not set those boundaries correctly you might end up in a situation where you isolate a rural area or isolate the providers within an alliance, even if it is voluntary. Or that the community rating premiums are set based on an area that is disproportionately unhealthy, for example, just because of the way the boundaries are set.

So I think Congress might need to think about legislation to make sure that those boundaries are set in ways that do not harm rural areas.

Mr. FLUHARTY. Mr. Stenholm, I would like to add in summary, because you and Mr. Strickland were not in at the start, that an overriding concern of both panels is that while many elements that all of you have already thought about are positive, one critical element being missed is the transition risk area. These concerns are absolutely critical if we incrementalize this process.

Second, an understanding of the fragility of rural areas must be included; and, as Dr. Mueller mentioned, you have this panoply of rural programs out here right now. It is important for Congress to understand how those work in an integrated system, and have reported to you, as this moves forward, whether it working or not in the fragility of the rural system and rural businesses sector. I think that is the second key issue.

The third we need to mention is, to the extent that we move to universal coverage, rural America benefits.

Mr. STENHOLM. Thank you.

Chairman POSHARD. Did you have another question?

Mr. STENHOLM. No, Mr. Chairman. I am going to have to leave.

Chairman POSHARD. I understand. Thank you for being here.

Mr. Strickland, thank you for being here and joining us at any time. We have an open mike here, and we are discussing things as we need to.

Mr. STRICKLAND. Thank you, Mr. Chairman, and I am sorry I was not here earlier. I find myself saying I am sorry more often than I would like around here.

On the question of universal coverage, I think some of us who have to vote on this bill may find ourselves confronted with a bill that is not exactly what we wanted, and it may have elements that we like very much and then elements that we do not like very much. And, for me, it is helpful to try to pick the brains of those who are not Members of the Congress and to see how people might feel who are out in the hinterland. I represent a very rural area.

I am wondering if you would not mind doing so—and if you do not want to, I understand—but if you could imagine that you were a Member of Congress and that you were going to be confronted with having to vote on a bill that did not provide universal coverage, that did many of the things that you thought may be helpful but did not provide universal coverage—and I don't want to get into whether or not that is through the employer mandates or

whatever. But how do you think you might react being confronted with that situation? Especially from the standpoint of being concerned about rural areas and its impact upon rural areas.

Mr. FLUHARTY. Let me start while our two panelists are thinking.

The greatest leap is to imagine ourselves as Members of Congress, Mr. Strickland, because that is extremely difficult for you all right now, as you know. We have thought a lot about that since it is so central to both of the panels' consensuses. I think it might be most appropriate to go at this question in terms of what both panels would consier in addressing their panel's approach to getting a handle on this issue.

Having grown up in the district above your own, Mr. Strickland, I think we both have a very good understanding about how rural parts of a State can be when it is called an urban State. Again, the universality issue means to the extent that everyone is covered, it is going to improve economic activity in all our rural counties, because those are human services that will be paid for there, and that are not currently, being offered or compensated for there.

Keith, would you comment?

Mr. MUELLER. I need to start with something of a caveat and say that on your question, which I will answer, I will be answering primarily from my own perspective and not that of the other five members of the delivery system panel.

Mr. STRICKLAND. Sure.

Mr. MUELLER. I believe there are two issues that are critical if you are confronted with a bill that does not immediately include or specify universal coverage by a date certain.

One of those is, on balance, what does this look like financially in terms of the kinds of revenue streams we have been talking about for the providers in rural America? If in not providing universal coverage we would still legislate the reductions in Medicare revenues to the providers and we would still legislate other provisions, say related to reductions in Medicaid or related to some of the other revenue-raising provisions that might affect rural, if we did that without having universal coverage I would have to say that, on balance, that is not good for rural, and I would have to say that I would probably oppose that.

The second issue that for me, again speaking for myself, is a critical issue, if the bill itself does not provide universal coverage but does not have the strong negative, now at least I reach a neutral position on the finances. Then the question is by voting for this bill and putting this in place is this a step forward from where we would otherwise be and can I come back to it later as a building block to add in provisions perhaps that we have talked about today for rural?

In there, my predisposition is that it probably would be a step forward, if it were at least revenue neutral for the rural providers. The reason for that is we have to compare it to current trends, and the current trends are not good for rural.

The trends of increasing concentration of market, if you will, in larger cities—for us in rural areas, a large city is 20,000—that kind of concentration of activity without some sort of public policy that reaches out to the smaller rural communities, the theme we devel-

oped earlier this afternoon about locally based, I think is bad for rural.

So if I can at least put in place a public policy now that enables me to begin to, at a minimum, provide some assistance and help to the rural communities as they face the changes already occurring, I think that is a step forward, and we would probably benefit from taking it.

Mr. MCBRIDE. I have a couple of things to add. I have to add the same caveat. We—in our panel, we did not talk about how we would vote necessarily. And, luckily, you are in that position, and we are not. But I will—I think there are a couple of things we discussed that might be relevant to your question.

One is—and this alludes to what Keith just said—we did look at at least one bill, the Cooper bill, that, on balance, we determined would not lead to universal coverage based on a CBO analysis, and we determined that it incrementally would also add to the economic activity of rural areas, perhaps not as much as the bills that achieved universal coverage. So, I think it is a matter of degree, and that may be relevant to your analysis.

And, second, there is one thing that pops in my mind that did not come up in our panel that you may want to do a little bit of thinking about and that is what you might—what might happen if you put in a bill that has insurance market reforms of the likes of community rating and no preexisting conditions being allowed and not having universal coverage?

The panel was a bit concerned that what you might have in that circumstance is create an incentive for people to drop their insurance coverage until they actually needed it because there would be no cost to doing so. Because now in our current system your premiums would go up or you would be denied coverage.

But if you institute insurance market reforms, which I see in every bill, then you take away that incentive for people to keep their insurance now, and you could actually lead to a situation where you might have some people dropping insurance coverage and that is one thing—one of the things you need to think about.

Health care reform is a very complicated legislation, and I think that is what your question is about. You need to think about how all the provisions will work together, and that is as difficult for us as it is for you, I think.

Mr. STRICKLAND. Thank you very much.

Mr. HEFLEY. How much thinking did you do about—did you even consider whether or not we needed some kind of radical reform, which is evidenced by the Clinton bill and most of the bills, of the approaches that you have considered? Did you consider maybe we do not need to go that far? Or did you accept as a foregone conclusion at the start of your study that we are going to have it? Now how do we protect rural interest in it? Which way did you approach it?

Mr. FLUHARTY. I think that might go to the baseline discussions. And, again, one of the problems we have here, as in all of rural, is an sufficient database.

One of RUPRI's greatest challenges is getting at a rural database for analytics. So, this panel spent time trying to arrive at a base-

line database, and that led to some assumptions regarding where we would go if we did nothing.

Keith, you could start, and then Tim.

Mr. HEFLEY. Not necessarily did nothing, but tried to fix some of the things that are broken without radically revising.

Mr. FLUHARTY. OK.

Mr. MUELLER. I am going to start with sort of a general response and then try to get specific to your question.

The general goes to the methodology that we used. This takes off from what Chuck just talked about. We began by saying, what is the current system and what are the trends in the current system? What would rural look like or what does it look like now? And then looked at specific pieces of legislation.

We began back in October with a first cut at the Health Security Act, and then we brought in six additional bills that covered what we thought was a spectrum of some incremental all the way to the Health Security Act and actually beyond it, if you will, to the single-payer legislation.

As we did that, our discussion and our thinking really moved away from trying to do a bill-by-bill analysis, even though that is what documents end up looking like because of the nature of how you organize written material.

But particularly in our more recent documents coming out of the service delivery panel and the one from which I spoke this afternoon we do not do that any more. We do not look at particular bills. Now what we are looking at are provisions that one finds in a variety of bills.

So even in legislation, Congressman Hefley, that is much more incremental in nature.

To go back to the specifics of your question, yes, we have thought about that because we have thought about provisions that are more incremental in nature, and we have moved away completely from trying to judge a particular bill as the bill stands by itself and move more toward provisions.

Mr. MCBRIDE. A direct answer to your question is—I think we did not directly answer that question—is the reform needed or not. We mostly wanted to just try to give an objective analysis on the three bills that we thought were—represented some sort of core of the debate at that point in time.

So I don't think we directly answered your question, although we talked about the incremental nature of some of these bills and where they might head if certain provisions were taken out, those sort of things.

Mr. HEFLEY. Now, Tim, on the economic panel particularly, you talk about your conclusion was that probably it would add to the economic activity in rural areas, and yet it is primarily the rural areas where the small business people come to me and say, if you do this, particularly with the mandates, that we are out of business and—because we know what the cost of our product or service is, and we cannot raise that cost. We know what the market will bear. We cannot raise it to do that, and we are out of business.

Also, in your study, in your conclusions, you say in the short run the impact on the economic status of rural families is unclear. Yet, everyone, including the President's Economic Adviser, predicts

there will be significant short-term job losses in low-wage, low-skill areas, which is the way you described earlier rural areas. How do you reconcile your conclusion that it will add to the activity with what people are telling me and what the economic advisers are telling us?

Mr. MCBRIDE. That is a very good question.

First, on the employer mandate. You are absolutely right as far as how the small businesses would be affected. We did certainly look. We spent a lot of time looking at the effects of the employer mandate both on employment and on wages and came to the conclusion that there were some relatively small on average impacts on businesses of the employer mandates.

So your point is not wrong. We would not disagree with your point. There are some small businesses that would be affected adversely. That is certainly true.

We can identify what some of those small businesses would be. They would be businesses that tend to have low-wage workers, especially with minimum-wage workers. Some smaller firms that might not have a profit margin to be able to absorb the employer mandate. Labor-intensive firms where labor is a high percentage of their costs or firms with young and healthy workers for which the community rating premiums would go up.

But the consensus opinion we arrived at which is, I think, a consensus opinion in the mainstream of the economics profession was that the majority of the mandate would be shifted back to employees in the form of lower wages, at least in the long run.

But again——

Mr. HEFLEY. Which exacerbates the problem they already have in the rural areas of having lower wages.

Chairman POSHARD. If the gentleman would allow me, I want to get into the specifics of what you found out with regard to your study, which is over in the Critical Component III: Rural Families, on page 25 of the study. I want to make sure I understand the conclusions that you have come to with respect to employer mandates.

You say, while overall well being may remain unchanged or improved during the transition, employer mandates lead to lower net wage income of rural workers during the 3 to 4 year transition period. This impact results from two separate effects. First, employees collectively pay an increased portion of premiums out-of-pocket. Second, the employer mandate increases the employer's payment on behalf of workers, on average, and a portion of that payment is passed on to workers. According to the RUPRI analysis of the Loprest et al. study, rural workers would lose $166 per year in net income. Job loss is estimated to be 81,000 jobs. Now this is nationwide. These negative wage and income impacts may be offset by increased access and coverage during the transition.

I want to be sure of what you are saying here. For universal coverage, for these rural workers who, for the most part, now are low-wage people who have no health care coverage whatsoever, they are going to get health care coverage, universal, for a net loss of $166 a year in income.

Mr. MCBRIDE. On average.

Chairman POSHARD. Is that right?

Mr. MCBRIDE. Right.

Chairman POSHARD. Now, the other thing I want to check out with you—because we have to look at all this on balance. The other thing I want to check out with you are the tables in your study that relate to that. Because I want to make sure that I understand these other figures.

The average reduction in net pay per worker, then, is $166 for the rural areas of this country.

Mr. MCBRIDE. Right.

Chairman POSHARD. OK. The average impact on employer per worker—now, I am assuming this is on balance when you take into consideration the totality of the employer mandate and the changes in pay.

Mr. MCBRIDE. Right, that is key.

Chairman POSHARD. The average impact on employers is $32 per worker on an annual basis.

So let me make sure I understand this. In order to achieve through employer mandate universal coverage, in totality now, when you consider the negatives as well as the positives of the program, it is going to cost the employer $32 per worker a year, when subsidies and everything else are figured in, and it will reduce the net pay of the average worker $166 per year. For that we get universal coverage through employer mandate.

Mr. MCBRIDE. That is true.

If I could interject at this point——

Chairman POSHARD. OK.

Mr. MCBRIDE. I agree with everything that you have interpreted. You have interpreted the tables correctly. The key point I think you are bringing out that I was going to mention to Mr. Hefley was that this is the impact on wages or the employer costs directly.

However, from an economist's standpoint, that is not the end of the story. The story is, is the well-being of the individual improved or not improved by the change?

One of the things I think you are bringing out in your question is for that cost of $166, on average, the employee is getting health insurance coverage, which may or may not be worth that much to them. We did not assess the value of that to them, but certainly it would have some value to some of them. Maybe not all of them. Maybe some are uninsured by choice. But certainly some of them it would have.

We did not offset the number. We put the number out here so that people would have an idea of what would be the direct impact on a person's paycheck. So, the key thing is to balance that against their well being.

One other quick point I would mention, which you alluded to, is this is an average. So, it includes people with both positive impacts on their wages and negative impacts. So, the number—maybe its seems small to some people. I don't know. But it is an average of positives and negatives as well.

Chairman POSHARD. But even if it is an average—and I realize there are many other things besides employer mandates and universal coverage that enter into this whole discussion. But just on those two things, even if that is an average, last year—and we have the studies to show this—the average premium per month for a middle range policy for the American family was $367 a month.

Mr. MCBRIDE. Right.

Chairman POSHARD. That is for an 80/20 policy with $500 deductible. When you include the 1.45 percent Medicare taxes as a part of our Federal income tax and then a portion of our State income tax for Medicaid, those five things alone—premiums, deductibles, copayments, Medicare and Medicaid taxes—cost the average American family last year $6,787 a year.

Now, if the tradeoff here for employer mandates and universal coverage and net loss in pay is anywhere close to what you are saying in your study, it seems to me that that has to enter into my thinking in terms of the way I see this whole problem, at least with respect to employer mandate and universal coverage.

Maybe there are other things that are out of balance with the Clinton plan or whoever's plan comes up that would cause me to vote no—abortion coverage or whatever else. But at least it seems that, on the basis , of the critical components of our discussion out here right now, whatever plan attempts to achieve universal coverage, at least at those levels, ought to be looked upon fairly favorably in a rural area. Am I wrong about that?

Mr. FLUHARTY. Mr. Chairman, let me interject so everyone is very clear. I think Tim may want to further explicate the assumptions in the Loprest study. There are some assumptions there that are critical. It was a basis. You might just expand a bit, Tim.

Chairman POSHARD. Sure.

Mr. MCBRIDE. Yes, one thing, if I could say before I get into the assumptions, which might get a little technical, that I would add to thinking more globally about it. Our conclusion is about rural families in general. So, one component of rural families in general is workers, and there are insured workers and uninsured workers. There are insured nonworkers and there are uninsured nonworkers and there are elderly families. We sort of split it that way.

So focusing in on that table is only one aspect of it. Our conclusion is based more on more than that. That is part of it, and that negative number there has to be offset against many other things, including the impacts, probably most specifically, on elderly families in the Clinton bill in specific, which is what we are looking at here, of the prescription drug and home health care program.

So let me throw that out as well. That you might—as the Congressman pointed out, that you might be a little jarred by the fact that our conclusion says one thing and the table has a negative number and how do you reconcile that. That is how we reconciled it.

Now, as far as the assumptions go on the Loprest study, we looked at a couple different studies to try to get a handle empirically about how you can measure the effect of the employer mandate. One was the Congressional Budget Office's analysis of the Aaron & Bosworth article that was recently in The Brookings Institution papers and this other article by Loprest and others from the Urban Institute.

We decided that both of them are relevant, and we did an analysis of both studies, but we came down on favoring the Loprest studies because it accounted for a great majority of the provisions of the Health Security Act as it modeled the effects of the employer mandate. So, it modeled the subsidies, it modeled the effects of commu-

nity rating, it modeled the effects of what the premiums would be in region versus region.

One of the key assumptions Chuck was alluding to, and it comes out in this table, is the assumption that 80 percent of the employer's portion of the health insurance premium would be passed on to the workers in the form of lower wages. So, in that number that you have cited, that is the key assumption.

Mr. FLUHARTY. Eventually.

Mr. MCBRIDE. Eventually, in the long run. So, that—to arrive at that number, that is how we got at that number. If our number was, for example, 100 percent, which some economists believe, then instead of the numbers being $166 and 32 all of it would be passed on to the employees.

Chairman POSHARD. OK. But again, we are looking at that in its totality, right?

Mr. MCBRIDE. Yes.

Chairman POSHARD. The 80 percent pass-through also includes the total picture. It includes the employer benefit in terms of subsidies and so on as well as what they are paying out in premiums, right?

Mr. MCBRIDE. Yes. One of the really good things about the Loprest study, we thought, was that it was able to model, to capture what currently their premiums are, if they are currently providing insurance, and compare that to where they would be under the new bill with all the subsidy structures put in place and all the 80/20 split between the employer and the employee and all the other provisions of the bill. So, it is a totality estimate, to the best that we could do. We wanted to——

Chairman POSHARD. I understand.

Mr. MCBRIDE [continuing]. questions about whether we should cite something so specific. So, I get a little nervous as an economist hanging my hat on something as specific as $166, but we are trying to give you a general direction which we think is important.

Chairman POSHARD. We realize that. There is no possible way you could be totally exact about all that.

Mr. MCBRIDE. Right.

Chairman POSHARD. I want to go on to your next chart before we leave this—or before Dr. Mueller talks about it, if he wants to—on the job losses per 1,000 persons from the employer mandates under the Clinton plan.

Mr. MCBRIDE. Yes.

Chairman POSHARD. Recognizing that the Clinton plan at this point in time may or may not be off the table—I don't know whether it is or it is not. But job losses per 1,000 persons, you estimate that on average, total, in the rural areas 1.69 job losses per thousand people. Is that correct?

Mr. MCBRIDE. Could I make a quick correction for you before we proceed?

Chairman POSHARD. Yes.

Mr. MCBRIDE. You will notice two columns there that fall under the real category, the nonmetro adjacent to metro areas——

Chairman POSHARD. Yes.

Mr. MCBRIDE [continuing]. and the nonmetro not adjacent to metro areas. So, probably would have been beneficial to average

those two so you could get it, but it is a combination of 1.50 and 1.69. Go ahead.

Chairman POSHARD. So about 1.6 job losses per 1,000 persons would be, in a sense, another negative tradeoff to the totality of things here.

Mr. MCBRIDE. Right.

Chairman POSHARD. So, in order to get universal coverage through employer mandate, as it applies to rural regions—and, again, I am doing this for my own benefit——

Mr. MCBRIDE. Sure.

Chairman POSHARD [continuing]. we are talking about, over the totality of the arrangement, an additional $166 a year per employee—I mean, lost wages for the employee, $32 a year, on average, for the employer, and a job loss of maybe 1.6 people per thousand to implement the program that way. That is strictly the economic side of this thing.

Mr. MCBRIDE. That is a correct interpretation.

Chairman POSHARD. OK.

Mr. FLUHARTY. I will add two points to cloud the water. What we have tried to do with both panels is not to give you academics who come in with two hands and say on the one hand, and on the other. We are trying to serve Members with a consensus opinion.

Chairman POSHARD. Yes.

Mr. FLUHARTY. This entire panel would have preferred to have broken the entire population into 16 segments and to have had a triple matrix for each. We are trying to serve Members by saying on the whole, where will rural be.

So to go back to the academic side and let the academic in me speak, there are some assumptions in the RUPRI Rural Baseline that also affect this. So, I need to reiterate, in addition to the Loprest assumptions, there are additional assumptions in the RUPRI Rural Baseline. But those having been given, that is correct.

Chairman POSHARD. OK. I'm glad you qualified that.

We have been joined by Ms. Danner from Missouri who represents a rural area also.

Ms. DANNER. That is true.

Chairman POSHARD. Or at least part of one. Pat, we are using open mikes here and just discussing and pitching in at any time you want to.

Ms. DANNER. I appreciate that.

Chairman POSHARD. So I will go to you now to see if you have any questions right now.

Ms. DANNER. I apologize, Mr. Chairman, for not having been present for more of the meeting, but, as you know, the Public Works Committee is meeting and that is on Superfund, which is a pretty important issue, too, and the votes seemed to call me, plus my constituents.

One of the questions I would have would be how valid is this study if indeed we are not looking at H.R. 3600? Because I don't think we are going to be looking at H.R. 3600, and one of the real problems I have with coming up into the closing weeks of the session, with a bill that we have not been able to give to you and have your expertise on, rather like we have H.R. 3600—and therein lies,

in my opinion, one of the problems that exists in this city. I would like to have had your expertise on whatever it is that we are presented with and the person says this is the bill we are taking to the floor of the House of Representatives. Now, academia, please react to it. That makes sense to me.

We have asked you to spend a lot of time and effort reacting to something that I have been told in two successive meetings, both morning and luncheon, that we are not going to be addressing, which is H.R. 3600.

All of that said, how will this relate to a bill that would be similar to H.R. 3600, for the most part?

Mr. FLUHARTY. Let me start and simply say we value you, Congresswoman Danner, from the Show-Me State. That is a Show-Me State attitude, by the way.

Ms. DANNER. Right.

Chairman POSHARD. These are all your folks.

Ms. DANNER. I know. Two out of three is not bad.

Chairman POSHARD. Except for Nebraska.

Mr. FLUHARTY. What we want to do is make science relevant to your policy decisions. The goal of RUPRI is to define the rural differential. It is difficult to hit a moving target, because each analysis does take time, but let me pledge to you, as soon as we have these two bills from the two chambers, these 16 scientists will be at work over the weekend and all night to try to give you that rural differential before you vote.

Ms. DANNER. I would very much appreciate that.

Let me say that I was one of the authors of the bill to resolve the Nebraska-Missouri dispute that Dr. Mueller may or may not know anything about with regard to Kissick Island in the Missouri River. So, perhaps he and I have even more in common than one might think. Although he is not from Missouri, in a manner of speaking part of his State is from Missouri.

Mr. MUELLER. Well, I can claim some residence. I grew up in the Kansas City area.

So I would like to add, to what Chuck said, one thing, and that is we realize that legislation is a moving target and that we did not look—and we had earlier conversation about a number of other, different bills that perhaps could have been examined—and one of the emphases that we are making today is we have looked at quite a number of different legislative provisions that are likely to show up in whatever comes out this week and next from the leadership and what is already in some of the bills we did not examine.

We would encourage you, as you might take an early look at the legislation before we complete the analysis Chuck just promised, to look at some of the provisions. You could look—for example, I have spent a lot of my time looking at provisions affecting rural facilities, and so there is a lot of language in our documents about that. You can go to the title of whatever bill comes out that is relevant to rural facilities and match that.

The same thing—I have also spent a lot of time looking at provider issues and medical education issues. Those are I think laid out very nicely in the delivery system panel documents.

So, there, again, you could look at the title of the legislation—it has traditionally been Title 3 for some reason in almost

everybody's bill—that looks at work force issues and see how that stacks up against some of our previous analysis.

That is what we will be doing as we move through analysis of the bills that come out. We will rely on a lot of what we have already done in just picking out the provisions now in this bill and seeing how they stack up.

Mr. MCBRIDE. I would echo that and point out that you are absolutely correct that those specific numbers cited in that table are only relevant to the Health Security Act as written.

But one of the things we did that analysis for, as I alluded to a minute ago, was to get an idea of the direction of the effect and perhaps the magnitude. We would probably feel a little more comfortable about the direction of the effect and the magnitude of the effect, if not the $166 in specific. That is probably one of the few examples in this report of a very specific conclusion of a very specific bill modeled on those specific provisions.

Most of our general conclusions are of the type that Keith alluded to, where it is more about the direction, the effect and sort of the overall effect of provisions. We feel, as an economics panel, that we have now—we have now hit the ground running, and that it would be very much possible for us to take another bill, whichever one comes out, the Gephardt mark, for example, or the Ways and Means mark and run with it.

A lot of those provisions are very similar to ones we have already looked at, and so this has helped us organize our thoughts and get some idea about the direction and the effect.

Ms. DANNER. Mr. Chairman, may I?

Chairman POSHARD. Certainly. Go right ahead.

Ms. DANNER. Keith, you mentioned facilities. Have you looked at what this means—and I apologize if I missed this because of my absence—what this means with regard to my rural hospitals? Is this beginning to be injurious—H.R. 3600—was that injurious to my rural hospitals?

Mr. MUELLER. No. Our conclusion specifically—since you put it in terms of H.R. 3600, our conclusion was that, on balance, rural facilities would be enhanced by the legislation. There are at least two reasons that immediately come to mind in thinking back over our discussions on that.

One—and it goes to a theme we have had all afternoon—is universal coverage is beneficial to rural facilities because its enhances their revenue flow. They no longer have to worry about uncompensated care.

Further, if you folded in to a new way of financing current Medicaid clients, which many of the bills also do, and thereby increase the payment coming from those clients, because Medicaid is one of the lowest payers now, that further enhances their revenue and puts them in a better position. So, enhancing revenue——

Ms. DANNER. Well, I would have to ask you—and we certainly know Medicaid and Medicare payments are less than they should be and are generally picked up by the private sector insurer. If we have more people coming through Medicare and Medicaid, aren't we going to be putting so much burden on private insurance that eventually it will collapse?

Mr. MUELLER. If you brought more people into the system under the current payment schemes in those two programs, you are correct.

What I alluded to when I mentioned Medicaid, in particular, is if, as is done in, again, several of the pieces of legislation we have examined over the last year, you in effect, eliminate Medicaid and instead offer those same clients vouchers or subsidies so that they can purchase the same private insurance that I purchase, which has the same payment to providers that my insurance has, you have just increased provider revenue.

Because now, instead of getting somewhere between 60 cents and 80 cents on a dollar of charges, the provider is going to get closer to a hundred cents on a dollar of charges.

I should also hasten to add I have carefully chosen my language here. Because every time we hear about cents on a dollar from providers, they tend to be telling us that in charges, which are discounted for a number of different people—Blue Cross does not always pay in some States, for example, as much as Medicare might pay because they have a bigger discount arrangement with the provider for passing those costs on.

In addition to the revenue enhancement, the other major reason we said facilities would be enhanced under H.R. 3600—and, again, under some of the other legislation as well—is that there are special efforts to help rural facilities redesign their service delivery or work with other rural facilities to achieve economies of scale.

There are in one provision we have not mentioned yet today—in I think just about every piece of legislation, there is some provision for safe harbor from antitrust activities, so that rural and small facilities could work collaboratively on purchasing arrangements and other ideas. That, we think, would help.

Enhancement of programs either exactly like the current essential access of rural primary care hospital program or something similar there to also help, and those are in 3600. They are also in many of the other pieces of legislation, including the Ways and Means mark that was completed a couple of weeks ago.

So enhancing the revenue flow through universal coverage and potentially through increasing what they currently get from Medicaid patients in particular and programs that are designed to assist them as they move into different modes of care or working together are the two major reasons we believe that, again, on balance, rural facilities would be enhanced by this kinds of legislation.

Ms. DANNER. Well, I think that something you have said speaks directly to my concern about looking at 3600 and now looking at what we are looking at. Because when you talk about the subsidy and then we think about private insurance the missing element here is Medicare C which is completely different.

I see your head is nodding because that is just a completely different approach, and you have had an opportunity to look at that, because that then goes back into government care. That is why I am just so nervous about this short period of time.

Chairman POSHARD. Would you address the Medicare C issue for a moment? I am glad you brought that up, Pat.

Mr. MCBRIDE. Our panel has not, as you know, had a chance to look directly at either the Ways and Means bill or, of course, the thing that is coming out tomorrow.

Ms. DANNER. Welcome aboard. I am a Member of Congress, and I have not seen it.

Mr. MCBRIDE. So this is my own opinion, or extrapolating from our panel's opinion. But your point is well taken, and Keith alluded to it a moment ago, that the way the Health Security Act is written, the people who are now in Medicaid handle themselves through the private insurance market, and that is the basis for our conclusions that hospitals would be better off under the provisions.

Now, if instead you channel them through Medicare part C—and I haven't had a chance to look at that provision specifically myself—and they would use Medicare payment methodologies—then you would have to ratchet down the payments that would go to the hospitals or other providers and that would tend to temper our conclusion. Although I would have to say that we do not know what the conclusion would be until our whole panel gets together. But you are certainly right about the direction of the effect.

Mr. MUELLER. I would just add to that, that is a very—I hate to give what is something of a standard answer about it being a very difficult question to analyze.

But the reason is, again, you have to compare it to something. If you say, on balance, are rural facilities better off or worse off, if you were to assume that everyone who came into Medicare part C was previously uninsured and, therefore, either paying part or none of any bill that they incurred, then you might still conclude that on balance you have increased the revenue of the provider.

But that is an important assumption to ponder because in rural areas some of the research that I have been involved in and directly in the literature that I have read indicates that the uninsured in rural areas currently do access health care. What we do not know is what is the level of payment they provide if they do not have any health insurance and they are using a hospital, let's say. What level of payment are they providing to the hospitals? If they are providing currently out of their own pocket a level of payment close the hospital charge, then we would have to say if you brought in Medicare part C and that is only 80 percent of charges, you have a net loss for the rural hospital.

So that is where the key assumption comes—is what are they paying now if they do not have health insurance versus what would they pay then.

We are on much safer ground in making the conclusion we did with 3600 if we know after the legislation they are going to be paying charges or almost 100 percent of charges, maybe some small discount, then we can really forcefully conclude we are better off.

If we know that after the legislation passes they are going to be paying some percent of charges based on whatever the Medicare-determined rate is for that year, we cannot be nearly as conclusive, but I would not automatically say that that makes the rural facility worse off. Because, again, it could be replacing what previously was a zero or even smaller percent payment from the same person.

Chairman POSHARD. I appreciate your offer to work on this over the weekend, because I tell you I think we are going to end up with

a Medicare part C on whatever bill comes to the floor, whether it be Mr. Gephardt's mark or the Ways and Means mark or whatever. To the extent that you could do some analysis of that now, we would really appreciate it.

Because I just had my hospital administrators out here the day before yesterday, and they were, of course, telling me that if we have to sustain more Medicare cuts, it is going to put some of them under—just as Mr. Hefley had indicated before.

But, when you look, again, at the whole situation based upon the way you assessed this, it is not as dire a situation as they make it look to be.

But if now we have a new part of the equation entering into it here, this Medicare part C, and that is going to perpetuate the same sort of system that we have had in terms of reimbursement, we are going to need to know that effect in some degree of specificity.

So if you could help us understand that, that would certainly enter into my thinking in terms of whether I end up supporting or not supporting a final bill.

Mr. FLUHARTY. We are certainly going to try, Mr. Chairman.

And, again, back to Congresswoman Danner, our earlier point was that the incremental nature of these decisions can put rural considerations at risk, and this is an excellent example. Where one tweak in a policy direction could be the incremental death of a rural facility. Conversely, one tweak in the other direction could sustain them over time, and that is why we have tried to look at total packages, and we will try to get that to you in a timely way, if we can.

Chairman POSHARD. OK. Do you have other questions over there?

Ms. DANNER. No, I am fine. Thank you, Mr. Chairman.

Chairman POSHARD. We are probably going a lot longer here than we had anticipated, but I am interested in the community health network grant program. Because it seems to me that one of the ways to increase cost efficiency in our rural areas is going to be some cooperation. Perhaps that can be achieved through the antitrust exemptions that, hopefully, will pass, although I know there may be some danger in that, too.

But I also had a couple of clinic directors out here recently who were telling me that the large regional type hospitals, 40, 50 miles away, have just made them an offer to buy out their clinic and buy up their practice. One said that has happened to every satellite facility in the area.

Is that good? Bad? Do we expect to see more of this? Is that going to increase the cost of health care in the rural areas if that trend continues? Or are we going to drive competition out the window? What is your sense of that?

Because that is happening now. I guess it is just the threats of reform that people are reacting to. But where are we going with that? How is it going to affect us, in your judgment?

Mr. MUELLER. I think you have raised what in my own thinking in the last few weeks is one of the most critical issues, and that is we are already headed down a certain path that is very different from what we have had in health care delivery for the last three

or four decades. With or without any action here over the next month and a half we are going there. The idea of regional hospitals purchasing practices for rural areas is one of the glaring examples.

Is it good? Is it bad? Well, the analyst in me says I need time to analyze it, of course, after it happens. The rural person in me says, I don't like it. It makes me nervous.

It goes to the point I made at the beginning this afternoon, and that is any change in health care delivery, if it is to be effective for rural citizens, needs to be locally based. To have regional hospitals buying up practices and making them satellites is not to have locally based health care decisionmaking, which I think is crucial.

What can be done about that? Your question started with the rural development grant program concept that is in much of the reform legislation and represents, I must say, a true success for you and your colleagues in rural health to get that into the legislation. I think that is critical.

There is in the most recent bills, including the Ways and Means mark, one element that could be incorporated into that program that I think would improve it a little bit more and maybe make it—and would make a difference, and that is providing what I would call pre-grant application technical assistance to the rural communities.

One of the reasons they are prey to this kind of purchasing activity you talk about is they do not really—they meaning the leaders of the community as well as the providers in the community—have a clear understanding of all of the changes that are occurring and what their community might want to put together as a plan.

So if you put out a grant program that says submit a plan to us so that you can get a rural development grant, you still will not get a locally based plan because they have not yet come to grips with how to do that. You would get a plan maybe written by a State Office of Rural Health. That is not to say they cannot do it. They do it well, and I work with them in my own State. But you would not get a truly locally based plan.

We believe it is important to provide some preliminary technical assistance, and in one of our documents we have suggested perhaps regional centers of technical assistance—although you could do it through State Offices of Rural Health if you are confident with that mechanism—but some kind of early technical assistance on the planning development side. Then have a development grant available after they have developed a locally based plan, so that they can do things like set up their own concept of what a clinic should look like in their community, who they can recruit for it, how they would work with other providers.

I think it is good in the legislation that there are requirements that certain types of providers be involved in whatever the ultimate network is so that you are sure a local community is going to work effectively with a full service hospital. I think that is important. But the plan would still come out of the local community, not from the full service hospitals, not from State government. It would come out of the local community.

Mr. MCBRIDE. If I could add something, and I think this is addressing your question with an anecdote that might be interesting.

I live in St. Louis, and one of the things we observed over the last year or so, since the President's plan was announced, that the three or four largest hospitals in St. Louis merged, financially at least. Now, from an economist's standpoint why would they do that?

Well, there was an article in the *New York Times* before the President's plan was announced that was predicting that all this was going to happen. They would do it for a simple reason, that if you set up a mandatory health alliance especially—or any kind of health alliance—the point of doing that in the first place was to increase the power of the insurance companies or whoever was running the alliance in the market sense so that they could go as a larger negotiator to the providers and negotiate lower payments.

So what would be the reaction of the providers on the other hand? Well, let's merge ourselves, make ourselves larger. So, that is when they go to negotiate with the health alliances they are a larger player. Then they tell us you need to lower your rate. Otherwise, we will not put you on our list. If you have 40 to 50 percent of the market in an area, an alliance is going to be pretty reluctant to cross them all off the list because their rates are not acceptable.

So there has been a lot of things put into place as a result of just the fact that Congress and the President are thinking about health care reform that are going to remain there.

One of the things you will need to think about, whatever legislation you pass or do not pass, those trends are going to remain there. Because I don't see any reason why these mergers would not remain in place because it will be helpful to them. So, that will remain in place no matter what you do, and you need to think about the implications of that and why it happened in the first place.

Chairman POSHARD. So are we economically building an economy of scale here which may benefit some organization like that in terms of profitability but creating less qualitative care?

Mr. MCBRIDE. I am not sure about the quality of care, but your analysis is correct in a certain sense. The economy of scale is the benefit for that organization. But the worry we may have on the other side is how that entity, which is now much larger, can behave in the marketplace and what rates it can charge. That is something we need to keep an eye on.

It may or may not be a bad thing. It may help quality of care, for example. We have heard a lot about the duplication of technology. If there is the same technology in two or three hospitals one thing they may do is consolidate the technology and try to get some economy of scale, which would be good.

So I am not saying universally it would be a bad thing. But it is an inevitable reaction to the health care reform in general.

Mr. MUELLER. If I could speak to the quality issue for a moment. I agree with Tim. Particularly in urban areas this kind of consolidation is probably an improvement in quality because of what you get in terms of the skill level of someone who does a procedure more often.

But if quality also includes measures of consumer satisfaction and time it takes to get to a provider and time spent at a provider's facility, this kind of consolidation, again if it is based in certain

larger communities, has the potential of lowering that measure of quality.

Would not necessarily lower my ultimate access to care if I just drive that 30 miles or 40 miles down to the physician's office. Would not lower the potential of me getting the high-tech, high-quality care we are proud of in this country. But if one measure of quality of care is a combination of consumer satisfaction and physical access, this kind of activity does have the potential of lowering that.

Chairman POSHARD. OK, thank you.

Pat, any other questions at this point in time?

Ms. DANNER. The only other thing I am concerned about—I have to read a little more about it because I did my Evelyn Woods on the *New York Times* this morning. As you know, you are supposed to retain and recall, and I don't retain and recall that much of the article, but I can remember there was a concern expressed—and this is particularly pertinent because of our teaching hospitals both in Columbia and in Kansas City—with regard to the fact that some of the New York hospitals, Mr. Chairman, were concerned about the fact that they were going to have fewer residents to staff their teaching hospitals.

For me in Kansas City that means Truman Medical Center, which is pretty much totally staffed by UM-KC. I am not all that familiar with Columbia—you would be, I assume—that it is staffed by UM-C.

Mr. FLUHARTY. Same situation, yes.

Ms. DANNER. And that is something that I am going to look into. I don't know whether you all can help me out with the university system in Missouri or not—most particularly after I just got through telling your President that I believe he allows too many TA's to be used at the University of Missouri who cannot speak English.

Chairman POSHARD. Every university in the country has that problem.

Mr. MUELLER. How about the residents? How is their language skill?

Ms. DANNER. But I am going to be pursuing that from other channels. But if you all in any way can help me with that question I would appreciate it very much. Because I am sure that that is not only pertinent to my district but to other districts as well.

Mr. MUELLER. Well, you raise a general area of deep concern to me. I am at the University of Nebraska Medical Center, so we share a lot of similar concerns to the Missouri medical institutions.

And, really, from our perspective, the critical issue is not in the context so much of am I going to have enough residents for teaching hospitals globally—and particularly enough residents for teaching hospitals in New York City, which may be the concern that the Times would focus on and certainly the concern of some of the other Members—but rather are we designing a training scheme appropriate to all regions and all specialties.

If we are going to get into work force issues, which all—again, as I said earlier, Title 3 of nearly every bill does this. Are we designing the system such that we will have an adequate supply of training physicians throughout the country?

One of the positions taken by the delivery system panel consistently has been that if you are going to get into the business of allocating residency slots around the country we need to allocate them in a manner that is equitable across what are the current 10 Public Health Service regions.

There is a very big concern in our part of the country, your State and mine, that if we reduce the number of residency positions in the subspecialties, which most people would agree will happen—and that is another thing that may happen in the absence of reform just by the nature of supply and demand.

If we do that and put in place a planning policy with national imperative that says we are going to allocate those positions, there is every reason to believe there is a risk that the new, reduced number of physicians would be concentrated in two or maybe three regions of the country. That we would have very big problems with, not only because we are a medical institution not in one of those regions but because of our concern for rural again.

If you train all the residents in places like New York City, Boston, Chicago, Los Angeles and San Francisco, what is the likelihood they are going to want to practice in Cozad, Nebraska, or in Cairo, Illinois, or in even Columbia, Missouri? Much less. But if we spread those positions around, we have a much bigger chance of also spreading our supply back to my distribution concerns.

Ms. DANNER. Excellent point.

Chairman POSHARD. Very good point.

Mr. FLUHARTY. Congresswoman Danner, that also goes to our concern that it is important that we think about a congressional oversight of the synoptic impact of overall national health reform on rural areas. This, to me, is one of the critical issues.

If we had a Rural Health Reform Commission that would report to this Congress as health reform is implemented, those issues could be monitored for Members that are concerned, and perhaps congressional action should be undertaken to accomplish this as reform is implemented. Otherwise, those rural impacts are going to be lost, as the broader juggernaut of reform goes forward.

Chairman POSHARD. Well, I certainly thank you for being here.

I have additional questions that I am not going to get to today, but I want to congratulate you on this report. I think it is one of the real significant contributions. We have 160-plus Members in our rural health coalition here, and will all of our people be getting copies of this?

Mr. FLUHARTY. Yes, I think the caucus intends to distribute that.

Chairman POSHARD. Great. I hope that is done. To the extent that you can analyze the additional things that are coming out tomorrow in the Ways and Means, I would really appreciate that. I think what you have done is made one of the real significant contributions to this debate, and I really appreciate it.

Mr. FLUHARTY. Thank you, Mr. Chairman.

Mr. MCBRIDE. Thank you.

Mr. MUELLER. Thank you.

Chairman POSHARD. So the meeting will stand adjourned. Thanks.

[Whereupon, at 4:23 p.m., the subcommitteee was adjourned subject to the call of the chair.]

APPENDIX

Congress of the United States

House of Representatives
Statement of Congressman Joel Hefley
Subcommittee on Rural Enterprises, Exports, and the Environment
July 28, 1994

Once again, thank you, Chairman Poshard, for holding these hearings on this very timely subject. The effort to reform our health care system is in its final stage, and I share your concerns that rural health care issues should receive more attention, though perhaps not for the same reasons.

I see our rural areas as the first test— the canary in the coal mine— of health care reform's success. I say that for two reasons.

First, rural areas are always hardest hit by government mandates. Minimum wages, Davis-Bacon requirements, and other federal laws raise the cost of labor and retard rural economic growth. For some advocates, you could argue that that was their intended purpose— to protect high cost labor against competition from low-cost labor. Whether it was their purpose or not, however, that was their result.

I suspect employer mandates will have the same impact. Areas with low costs and labor intensive jobs— rural areas, in other words— will shoulder a large portion of the burden. Employers in these areas don't have the resources necessary to cope with another wage tax and employees will be laid off. I suggest that having health insurance is small consolation for someone without food on their table or a roof over their head.

Second, rural health care problems pose the greatest hurdle to health care reform. Rural areas have large populations of uninsured, low-income people. If we are going to live up to the President's promise of universal coverage, we need to solve the health problems facing rural areas.

In that respect, I have before me a study conducted by the National Center for Policy Analysis conducted in 1991 which looks at rural health care availability around the world.

One conclusion I draw from this study is that rural health care concerns are universal. The problems facing my constituents in eastern Colorado are similar to those experienced in Northern Canada or along the Rhine in Germany: limited access, no specialists, poor equipment, etc.

The other conclusion I draw is that national health care is no solution to rural health care's problems. Consider the following findings:

People living in British Columbia's two largest cities receive 55 percent more specialists'

services per capita than rural residents. British Columbia's urban residents are 5 1/2 times more likely to receive services from a thoracic surgeon, 3 1/2 times more likely to see a psychiatrist, and 2 1/2 times more likely to receive services from a dermatologist, an anesthesiologist, or a plastic surgeon.

- After 40 years of national health care, people in rural England still have to travel to urban areas to access CAT scans and other modern medical technology.

- In Norway, residents of Oslo are 15 times more likely to see a specialist than people living in the northern part of the country.

- In Brazil's free health care system, urban residents see doctors nine time more often as rural residents.

- Venezuela promises free health care to everyone, but all of Venezuela's free health care clinics are located in large cities.

- In Mexico, where free health care is a constitutional right, 85 percent of the health care resources are consumed by 35 percent of the population, mostly residing in large cities.

In other words, universal access is a myth. You can promise it, but you can't deliver it. Worse, government intervention in these countries has reduced the quality of the care their citizens receive. Consider that both Canada and England have severely limited the access to such life saving procedures as open heart surgery and brain scans. (I ask that a summary of the NCPA study be included in the record at the appropriate place.)

In conclusion, let's not lose sight of the forest for the trees. People who live in rural areas— by definition— have less access to most of the services we take for granted in urban areas, including health care. If they had the same access, they wouldn't be living in rural areas!

This fact of rural life poses special problems that we need to tackle in order to ensure health care availablity for our rural population. For the reasons I stated above, however, increasing the role of government in our health care system is not the solution.

To the contrary, I think the record is clear that excessive government involvement exacerbates those problems, lowering access to care while reducing its quality. To suggest otherwise is to ignore the experiences of Canada, England, and other countries that have experimented with with national health care.

Once again, I want to thank the Chairman for holding this hearing and I look forward to hearing the testimony of the witnesses.

103d Congress

United States House of Representatives
Committee on Small Business
Subcommittee on
Rural Enterprises, Exports, and the Environment
509 Ford Office Building
Washington, DC 20515

OPENING STATEMENT BY CHAIRMAN GLENN POSHARD
SUBCOMMITTEE ON RURAL ENTERPRISES, EXPORTS AND THE ENVIRONMENT
HEARING ON HEALTH CARE AND RURAL SMALL BUSINESSES
JULY 28, 1994

Good afternoon. Today's hearing will examine the economic implications of health care reform legislation for rural small businesses and the rural economy.

The health care debate has entered yet another crucial stage on Capitol Hill and across the country. One result of arriving at that stage is the current effort of Majority leadership here in the House to craft a new bill that can pass and that can achieve the President's major reform goals - universal coverage and cost containment.

As rural advocates, many of us have felt in recent months that we have had some significant success. We have included provisions important to rural America in the reform bills that have moved through various committees. Now, as it appears that a new bill is emerging and likely will be the bill that we in the House finally consider, we feel it is necessary to maintain our profile as advocates for rural communities.

It's important to remind our colleagues that the special conditions and problems of rural communities will require certain special provisions. Rural communities stand to gain a great deal from reform of the country's health care system, especially from reform that does deliver on the promise of universal coverage. Rural communities might even benefit relatively more from reform than other communities, if reform is done properly. But the way we do reform could also pose new threats to rural communities and their health care delivery systems. We will hear about both the threats and the opportunities today.

This hearing follows one that the Subcommittee conducted on June 23. That hearing focused on H.R. 4555, the Rural Health Delivery System Development Act - a bill introduced by Representatives Stenholm and Roberts, of which I was an original cosponsor. A number of important provisions of 4555 were included in H.R. 3600, the Ways and Means Committee bill, and some of us are working now to see if we can include those provisions and others in the new Majority bill.

Today we will focus on findings of analysis carried out by the Rural Policy Research Institute (RUPRI) on health care reform and the rural economy. The academic experts that RUPRI has assembled through its research panels have made invaluable contributions to the health care debate already this year. RUPRI analysis and recommendations were the basis of much of the bipartisan rural bill I mentioned earlier, and RUPRI economists provided important testimony at our first hearing, as they have before other committees around the Hill. RUPRI economists conducted a very interesting and useful briefing in the Cannon Building just last week. I point out that this is an independent collection of economists, and I believe a range of ideological views have been taken into account into the consensus documents they have produced. Their reports are purely non-partisan.

Of course we are interested today in RUPRI's most recent analysis, found in the document that members have before them. And we are particularly interested in the implications of their findings for the still-evolving proposal that we in the House will soon consider. If I can steal our witness's thunder to make one point, it is this: RUPRI economists believe that health care reform done properly, with universal coverage, will benefit rural America's economy, will benefit its health delivery system, and will on the whole benefit rural small firms.

I hope our hearing can clarify how rural America is faring so far in the legislative process. I hope the testimony can help explain how the still-changing reform proposals will likely affect rural communities. And I hope the hearing can help us determine what are the important next steps for rural advocates.

The Subcommittee knows Mr. Fluharty, who is Director of RUPRI and who is based at the University of Missouri. We also welcome Dr. McBride of the University of Missouri, and Dr. Mueller, who is Director of the Nebraska Center for Rural Health Research. I am very pleased we have both of RUPRI's expert panels represented here today - the economics panel and the health delivery system panel.

THE RURAL PERSPECTIVE ON
NATIONAL HEALTH CARE REFORM LEGISLATION

Testimony by
Charles W. Fluharty
Director, Rural Policy Research Institute

on behalf of
RUPRI RURAL HEALTH ECONOMICS EXPERT PANEL
RUPRI RURAL HEALTH DELIVERY EXPERT PANEL

Mr. Chairman, Mr. Hefley, and distinguished members of this subcommittee, The Rural Policy Research Institute (RUPRI) appreciates your leadership in holding the Hearing to discuss the rural impact of national health reform, at this critical stage in the legislative process. As you know, contrary to popular belief, the population of rural America is not shrinking but continuing to grow. Congressional decisions regarding health reform will profoundly impact the health of the approximately 52 million Americans living in rural areas, as well as the future of their health delivery systems and rural economies. It is critical that the unique circumstances of rural America are fully understood by Congressional decision makers as they finalize national health reform legislation.

As you know, RUPRI currently has two distinguished national Expert Panels assessing the rural implications of health reform, as a decision support vehicle for Congressional decision makers throughout the design, implementation, and evaluation of national health reform. Our testimony today will focus primarily upon the work of our Rural Health Reform Economics Expert Panel. Panelist Timothy McBride, Ph.D., will present an overview of this Panel's initial analyses of the rural economic impacts of reform legislation. Dr. Keith Mueller, representing our Rural Health Delivery Expert Panel, will discuss the consensus opinions of this Panel regarding the impact of reform upon

the health delivery system in rural America. Their comments are based upon Briefing References Documents developed by each Panel. We also welcome the opportunity to discuss specific components of the evolving House legislation currently under consideration. Obviously, neither Panel has had an opportunity to review this legislation, but most key components have already been analyzed by each Panel.

Two general observations are most pertinent. First, if appropriately designed and implemented, national health reform will have major positive impacts upon rural America. However, reform which does not fully take into consideration the fragile nature of the rural economy, the rural health delivery system, and the lives of many rural families could have significant negative effects. Second, because of this, the transition period from our current health delivery system to the reformed structure is critically important. Great care must be taken to assure that rural America is not unduly harmed as national health reform begins to take effect.

Mr. Chairman, the specific concerns regarding all of these issue will hopefully be discussed during this Hearing, and we welcome this dialogue. Thank you again, on behalf of all rural Americans, for the leadership this Subcommittee provides in continuing to focus upon the critical importance of these issue for rural America.

THE RURAL PERSPECTIVE ON
NATIONAL HEALTH CARE REFORM LEGISLATION

Testimony by
Dr. Timothy D. McBride, Ph.D.
Assistant Professor of Economics, Public Policy and Gerontology
University of Missouri-St. Louis
St. Louis, MO 63146

on behalf of
RUPRI RURAL HEALTH ECONOMICS EXPERT PANEL

Mr. Chairman, Mr. Hefley, and members of the committee: On behalf of the RUPRI Rural Health Economics Expert Panel, I want to thank you for inviting us to testify this afternoon. As you know, the health care reform legislation currently under consideration will have major impacts on rural areas. Thus, it is important for Congress to think about the impact of health care reform on rural areas and we welcome the opportunity to present our views to you.

As the Chairman knows, our Rural Health Economics Expert Panel completed a Briefing Reference Document last week. My testimony here today is based on this document and, with the chair's permission, I would like to submit that document into the record.

The Briefing Reference Document provides the panel's initial analyses of the impacts of reform on rural areas. Although our panel has been working to develop these consensus opinions, I must repeat these are ***preliminary***. Because the health care sector is immense, changes of the magnitude currently being discussed will have profound impacts on the rural economy. Our panel has not had sufficient time to investigate all of these implications, but we are engaged in ongoing analysis and we are here today to provide

some early consensus opinions.

Mr. Chairman, I appear here today as a representative of the 11-member Expert Panel. Wherever possible, I will try to provide you with the consensus opinions of the panel, not my own opinions. However, if the questions take us into areas that have not been fully investigated by the Panel, I will indicate so and attempt to offer my own opinions.

In developing this analysis, the Panel studied three major health reform proposals on the assumption that it would be enacted as introduced. These bills were examined with specific attention to the economic impact of each proposal on four components of the rural economy:

I. Rural Health Care Business
II. Other Rural Businesses
III. Rural Families
IV. Rural Local Governments

While the analysis contained in the reference document is rather extensive, several general Panel consensus opinions would serve well to focus today's discussion:

- ☐ Health care reform will have a positive impact on the economic status of rural areas, assuming key conditions are met.

This conclusion is based largely on the special characteristics of rural areas. For example, rural areas tend to have a higher proportion of elderly people, small businesses employing less than 100 workers, self-employed individuals, relatively low-wage jobs, employees purchasing insurance without employer assistance, hospitals more heavily

dependent on Medicare and Medicaid payments, and hospitals with total expenses exceeding total revenue.

The three legislative proposals we analyzed to date contain some provisions that will harm some people in these groups. However, on balance we feel that the proposed legislation contains enough provisions that aid individuals in these groups to lead to our conclusion that reform legislation will benefit rural areas.

While specific provisions in the bills are specifically beneficial to rural areas, we are convinced that the major benefits of the health care reform proposals stem from their impacts on special population groups represented in rural areas. This is important, because it suggests that Congress needs to think carefully about these groups as it finalizes this legislation.

Despite our panel's conclusions about the benefits of health care reform for rural areas, our panel has raised a number of significant concerns about this proposed legislation.

- ☐ We are concerned about the viability of the rural economy in the ***transition*** period. The economic status of many rural businesses, families, and governmental bodies is fragile. It may be difficult for many of these businesses, families, and jurisdictions to adjust to the provisions of health care reform legislation. Our panel urges that lawmakers think carefully about transition provisions that could help rural institutions adjust to contemplated changes.

- ☐ Our analysis and conclusions regarding these positive health care reform impacts on the rural economy are based on the full provisions of the three bills we considered. Changes in the legislation, or incremental adoption, could have serious negative consequences for rural areas. Congress must consider these impacts as final legislation is debated.

- ☐ The panel's positive consensus opinion about the impacts of health care reform legislation is based largely on provisions that expand access to health care for rural Americans. In particular, we feel that universal coverage would be particularly beneficial to rural areas and that many of the positive impacts of health care reform will not be realized if the legislation does not eventually lead to universal coverage of rural persons.

Our panel has enumerated a number of more specific concerns about health care reform legislation in the Briefing Reference Document. I would be pleased to discuss these in more detail here.

We hope this Briefing Reference Document and Testimony will be helpful in considering the rural economic impacts of key reform components currently under consideration. We thank the committee for inviting us here today to share our preliminary views.

RUPRI RURAL HEALTH REFORM ECONOMICS EXPERT PANEL

Bruce Bullock, Ph.D., University of Missouri
Ralph Christy, Ph.D., Cornell University
Sam Cordes, Ph.D., University of Nebraska
Gerald Doeksen, Ph.D., Oklahoma State University
Mark Edelman, Ph.D., Iowa State University
Tom Johnson, Ph.D., Virginia Polytechnic Institute & State University
David Holland, Ph.D., Washington State University
Tim McBride, Ph.D., University of Missouri
Shirley Porterfield, Ph.D., Washington University
Ron Shaffer, Ph.D., University of Wisconsin
Ron Young, Ph.D., Kansas State University

RUPRI RURAL HEALTH REFORM EXPERT PANEL

Andrew Coburn, Ph.D., University of Southern Maine
Sam Cordes, Ph.D., University of Nebraska
Robert Crittenden, M.D., University of Washington
J. Patrick Hart, Ph.D., Northern Wisconsin AHEC
Keith Mueller, Ph.D., University of Nebraska
Wayne Myers, M.D., University of Kentucky

HIGHLIGHTS OF CHAIRMAN PAT WILLIAMS' RURAL INITIATIVE

Funding:

A Rural Health Care Fund has been established to fund this initiative. This means there will be a guaranteed, dedicated funding stream coming from a small assessment on the premiums.

The provisions in this initiative include:

- increasing funding for rural and frontier areas to help them develop their own community-based health plans; among other things, funds can be used to develop provider networks, telecommunications capability, and transportation services ($50 million)

- increasing funding for hospitals and outpatient facilities in medically underserved rural communities to help them increase their ability to provide more primary care services; among other things, funds can be used to renovate facilities, develop rural emergency access care hospitals, and develop nurse managed health centers ($100 million)

- providing authority and funding to conduct research and demonstration projects to identify innovative and resourceful ways to provide health care in rural and frontier areas ($25 million)

- increasing funding for rural areas to strengthen their ability to provide Emergency Medical Services; the money will be primarily for training of personnel and purchase of equipment and vehicles ($100 million)

- setting aside funds to train non-physician providers, including nurse practitioners, physician assistants, and nurse midwives, with the funds going to programs that have a substantial number of their graduates practicing in rural areas ($50 million)

- providing authority to allocate training slots for nurses and physicians by giving priority to training programs that have a history of producing providers that actually practice in rural areas

- ensuring equitable distribution of grants for capital improvement and development of practice networks among rural and urban areas

- permitting Medicare-dependent hospitals (ones that have Medicare beneficiaries for 50 percent or more of their patient population) to be eligible for vulnerable population adjustments

- establishing a National Rural Health Advisory Committee that will advise the National Health Board, the Secretary of the Department of Health and Human Services (DHHS), and the Director of the Office of Rural Health Policy within the DHHS; committee is required to include at least one nurse practitioner

Comparison of Rural Health Provisions
July 18, 1994

Rural Health Delivery System Development Act	Ways and Means Committee
Rural Health Network Development ●Establish Chronically Underserved Areas to receive priority assistance for State Access Plans and Technical Assistance Grants ($10m over 3). ●Technical Assistance Grants for networks ($10m over 5). ●Community Rural Health Network Development Grants ($100m over 5)	●Establish Community Health Network grant program ($160 million) to facilitate delivery of health services in underserved areas. Includes rural health clinics, rural referral centers and sole community hospitals. ●Federal grants to support managed-care programs in rural areas. ($50m over 5 yrs.)
Incentives for Health Providers in Rural Areas ●Exclude NHSC loan repayments from gross income. ●Amends HPSA to take into account Medicare, Medicaid and uninsured population. ●Direct at least 20% of scholarships and loan repayment programs to include nurses ●Increase Mental Health Professionals in HPSAs. ●Extend Medicare bonus payments to physicians in HPSAs for 3 years. ●Adjust geographical indices for physicians. ●Defer student loans for interns and residents. ●Develop model state scope of practice.	●Increase Medicare bonus payments for primary care to 20% and extend payment to physicians for 3 years. ●Establish national health care work-force plan to provide for at least 55% of all residents be in primary care by 1998. ●Tax credits for primary care providers ($1000/mth for physicians, $500 for NPs, CNMs, and PAs.)
Incentives for Rural Health Facilities: ●Increase funding for Community Health Centers ($650m over 5) and Migrant Health Centers($75m over 5.) ●Create Federal Office of EMS ●Grants to improve EMS in rural areas. ●Grants for Telecommunications Demonstration projects in rural areas. ●Grants to enhance emergency air transport systems ●EACH/RPCH Amendments ●Establish REACH facilities ●GME Demonstration projects to encourage primary care	●Increase expensing limit for medical equipment to $10,000 in underserved areas. ●EACH/RPCH expanded to all states, increased to $90m/year ●Establish Capital Financing Trust Fund to assist EACHs, RPCHs, and ECP facilities.(DSH hospitals, rural health clinics, RRCs and SCHs in rural areas) $980m/yr. ●Create Federal Office of EMS ●Grants to improve EMS in rural areas. ●Grants for Telecommunication demonstration projects ($2m from Transition Grant program) ●Grants to enhance emergency air transport systems. ●GME demonstration projects and incentives for primary care sites in underserved areas. ●Cost-based reimbursement from private health plans for Rural Health Clinics and FQHCs. ●Require rural clinical practice criteria to be taken into account when developing quality measures. ●Mandatory contracting by health plans with independent providers serving in HPSA or MUA.
Border Health Commission. ●Establish US-Mexico Border Health Commission	●Establish US-Mexico Border Health Commission
Antitrust Relief ●Relax standards for hospitals in rural areas that attempt to consolidate or share services.	No Provision.

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THE RURAL PERSPECTIVE ON NATIONAL HEALTH REFORM LEGISLATION

Economic Implications for Rural Small Businesses, Citizens and Local Governments

Briefing Reference Document
in Support of
Testimony Presented to

The House Committee on Small Business
Rural Enterprises, Exports, and the Environment
Subcommittee

July 28, 1994

UNIVERSITY OF ARKANSAS • IOWA STATE UNIVERSITY • UNIVERSITY OF MISSOURI • UNIVERSITY OF NEBRASKA

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INTRODUCTION

This Reference Document supports a July 28, 1994 Hearing testimony, requested by the Rural Enterprises, Exports, and the Environment Subcommittee of the House Committee on Small Business to address the impacts of national health reform legislation on rural families, rural businesses, rural health delivery systems, and local rural governments. This document reflects minor revisions made following a July 20, 1994 Congressional Briefing, requested by the Congressional Rural Caucus and the House Rural Health Care Coalition.

This analysis was developed by the RUPRI Rural Health Reform Economics Expert Panel, a distinguished group of nationally recognized economists assembled by the Rural Policy Research Institute to serve as an ongoing research and decision support resource for policy makers throughout the design, implementation, and evaluation of national health reform. Members of this panel are listed below:

RUPRI RURAL HEALTH REFORM ECONOMICS EXPERT PANEL

Bruce Bullock, Ph.D., University of Missouri
Ralph Christy, Ph.D., Cornell University
Sam Cordes, Ph.D., University of Nebraska
Gerald Doesksen, Ph.D., Oklahoma State University
Mark Edelman, Ph.D., Iowa State University
David Holland, Ph.D., Washington State University
Thomas G. Johnson, Ph.D., Virginia Polytechnic & State University
Timothy D. McBride, Ph.D., University of Missouri-St. Louis
Shirley L. Porterfield, Ph.D., Washington University
Ron Shaffer, Ph.D., University of Wisconsin
Ron Young, Ph.D., Kansas State University

METHODOLOGY

The analysis which follows was developed by the RUPRI Rural Health Reform Economics Expert Panel, to provide an understanding of the rural economic impacts of three national health reform legislative proposals , selected because key components of these bills, in one form or another, remain central to the legislative debate and decision making process as final health reform packages are being considered in each House of Congress:

S 1770 - Health Equity and Access Reform Today Act of 1993 (Chafee)
HR 3222 - Managed Competition Act of 1993 (Cooper)
HR 3600 - Health Security Act (Gephardt/Clinton)

This analysis presents the current thinking of this Expert Panel, and is based upon Congressional Budget Office analysis of HR 3600 and HR 3222. Since a CBO Study of S 1770 has not yet been released, the Panel was forced to develop its own preliminary analysis of the expected rural economic impacts of this proposal. When a CBO scoring of S 1770 is released, the Panel will re-evaluate its findings accordingly.

A final report will be developed by this Panel over the next 60 days, in response to questions and suggestions received during this Briefing, as well as subsequent discussions with Congressional decision makers. That final report will also incorporate additional analysis of aggregate economic impacts developed through RUPRI's regional and Met/Non-met econometric modelling capability.

In developing this analysis, this RUPRI Expert Panel studied these proposals on the assumption that they would be enacted, as introduced. The Panel examined each bill, with specific attention to the economic impact of each on the following four components of the rural economy:

I. Rural Health Care Businesses
II. Other Rural Businesses
III. Rural Families
IV. Rural Local Governments

Following delineation of these impacts, the Panel has also listed additional concerns regarding these legislative components.

OVERVIEW

There are differences in several key economic characteristics that distinguish rural from urban areas, which may generate a rural/urban differential in health care reform consequences. Rural areas tend to have a higher proportion of elderly people, small business employing less than 25 workers, self-employed individuals, relatively low-wage jobs, employees purchasing health insurance without employer assistance, hospitals more heavily dependent on Medicare/Medicaid payments, and hospitals with total expenses exceeding total revenue. In addition, the relatively sparse population density of rural areas creates specific challenges related to the cost of delivering quality health care services to rural citizens.

Given these differences, several components of proposed health care reform proposals require particular attention when assessing rural economic impacts:

A. The extent to which the proposal intends to achieve universal coverage, as well as the proposed method for attaining this goal.

B. How effective the program will be in achieving cost containment, as well as the rural/urban distribution of benefits (and/or costs) of achieving this control, as well as specific approaches used to contain costs.

C. Both rural hospitals and households will be impacted by Medicare and/or Medicaid changes. Changes in either funding levels or administration and implementation procedures will be particularly critical.

D. Specific details regarding community rating boundaries and processes.

E. Specific details regarding health care service purchasing organizations.

F. The distribution of program development and management responsibility between national, state and local governments.

CRITICAL COMPONENT I: RURAL HEALTH SERVICES BUSINESSES

The health sector in many rural communities is much more than just a provider of medical services. In many rural communities, the health sector is a major employer and thus very important to the communities' economic health. In many communities, the health sector accounts for about 15 percent of the communities' employment. When secondary benefits are included, the sector often accounts for 20 to 25 percent of employment. Medical programs such as Medicare, Medicaid and private insurance bring dollars into the local economies of rural areas. Health reform proposals which increase the ability of rural communities to attract medically related employment, income and demand are important, therefore, to the future prosperity of rural communities.

All health bills proposed include either universal access or universal coverage which will increase the demand for health services in rural areas. The more these bills increase coverage, and thus demand for health care, the more potentially beneficial they are to the health care businesses in rural areas. All bills also have features which increase health facilities. The key question becomes whether the professionals and facilities will be available to meet the increased demand.

The current trend, in which urban health delivery organizations are enticing health professionals from rural areas, is a serious concern for rural areas. Once a community loses its health care professionals it will be difficult or impossible to reestablish the service later, if and when the availability of professionals increases. Furthermore, as it takes longer for the availability of health care professionals in rural areas to increase, then more communities will lose there health care services permanently.

I. **Compared to the continuation of current trends, will the level of economic activity of rural health businesses be enhanced, diminished or unaffected if the bill is enacted as introduced?**

HR 3600 HEALTH SECURITY ACT OF 1993

EXPERT PANEL CONSENSUS: IN THE LONG RUN, THE AMOUNT OF AGGREGATE ECONOMIC ACTIVITY IN THE RURAL HEALTH SECTOR WILL INCREASE. IN THE SHORT RUN, THE IMPACT OF THIS BILL IS INDETERMINANT.

RATIONALE:

Considerations which would enhance the supply of health care professionals in rural areas include:

1. National Council of Graduate Medical Education (GME) would set the total number of specialists by location every three years assuring that 55 percent of residents starting training in 1998-99 will be primary care providers. This should slowly increase the supply of health care providers to non-metro areas.

2. Tax credits to areas of provider shortages (which are largely non-metro) should increase the level of rural health care providers relative to metro areas.

3. Medical equipment used in practices in shortage areas could be expensed up to $17,500.

4. Increased funding of Migrant and Community Health Centers would increase the employment of health providers in non-metro areas.

5. Grants would be available to train primary care professionals and displaced health care workers. (The goal would be to expand community based generalist training, increase the supply of physicians in rural areas, and increase minority and nurse practitioner, and nurse midwife training).

6. Since non-metro areas currently have lower levels of coverage and therefore lower expenditures, universal health care insurance coverage should disproportionately increase the need for employment in the non-metro health care sector, as compared to metro areas.

7. A new grant program would provide home and community-based services for severely disabled people ($4.5 billion in fiscal year 1996). With the higher proportion of elderly in rural areas, it is expected that this program would be expected to increase demand more in non-metro than metro areas.

8. A grant program would authorize $2.7 billion (1995-2000) to recruit, compensate, and train health professionals and administrative staff, provide facilities, and develop administrative systems in designated shortage areas.

Considerations which would enhance rural health care facilities include:

1. Increased funding for Migrant and Community Health Centers;

2. Funds for assisting Accountable Health Plans in non-metro and underserved areas with capital needs;

3. A grant program for home and community-based services for severely disabled people;

4. Coverage of prescription drugs for outpatients under Medicare;

5. Universal coverage would increase revenues for rural facilities; and

6. Assistance to develop rural networks and health plans.

CONCERNS:

1. The bill will immediately increases the level of demand for health care professionals. However, the features of the bill which expand the supply of health care professionals will take a number of years to become effective. In the mean time, some rural communities will be unable to maintain their medical capacity.

2. The effectiveness of health care professional supply enhancement features of this bill may be limited unless it also assures that rural areas have modern, efficient facilities (to support telemedicine for example) in place when the supply of professional increases.

3. It is not clear how the insurance sector will be affected by changes in the insurance delivery system caused by this bill.

4. This bill caps growth in Medicare expenditures and private premiums. If costs increase faster than constrained revenues, some rural facilities may no longer be economically viable.

5. Approved health plans are allowed to contract exclusively with single source suppliers, which could mean many small independent service providers such as pharmacies will lose significant amounts of business to larger chains.

I. **Compared to the continuation of current trends, will the level of economic activity of rural health businesses be enhanced, diminished or unaffected if the bill is enacted as introduced?**

HR 3222 MANAGED COMPETITION ACT OF 1993

EXPERT PANEL CONSENSUS: IN THE LONG RUN, THE AMOUNT OF AGGREGATE ECONOMIC ACTIVITY IN THE RURAL HEALTH SECTOR WILL INCREASE, BUT LESS THAN UNDER UNIVERSAL COVERAGE. IN THE SHORT RUN, THE IMPACT OF THIS BILL IS INDETERMINANT.

RATIONALE:

The Congressional Budget Office estimates that an additional 15 million people will be insured by the universal access provisions of this bill. Since rural areas have a slightly greater proportion of uninsured than urban areas, as well as older and poorer residents with higher rates of unemployment and chronic illness and disability, demand for services will increase, absolutely and proportionately, but not as much as under universal coverage.

Considerations which would enhance the supply of rural health care professionals include:

1. The Health Care Standards Commission would specify the number of primary care physicians, and vary medical education payments, depending upon whether residents are in primary care or some other medical specialty;

2. Funds would be available for retraining surplus medical sub-specialists in primary care;

3. Funding for the National Health Services Corp. would be increased $25 million per year;

4. GME funds would flow directly to residency training programs;

5. Teaching programs would be reimbursed at a higher rate for primary care residents than for residents in referral specialties; and

6. Referral specialist reimbursement by Medicare would be selectively reduced, which could direct physicians toward primary care.

Considerations which enhance rural health care facilities include:

1. Funding would be increased for Migrant and Community Health Centers ($100 million per year from 1995-1999);

2. Grants would be available to develop and implement accountable health plans in rural areas;

3. Hospitals with disproportionate share under Medicare and hospitals with patient care operating deficits would be eligible for special transitional assistance;

4. Technical assistance would be available for establishing network plans in rural areas;

5. A new program would create a new classification of Rural Emergency Care Hospitals, which would be eligible for Medicare reimbursement; and

6. Requirement to adjust payments allowing for risk adjustment factors would increase compensation to accountable health plans serving persons in medically underserved areas.

CONCERNS:

1. Many rural areas are already experiencing a short supply of physicians and mid-level professionals. In addition, many of the physicians in rural areas are near retirement. These facts, plus the recent trend of urban HMO's, PPO's and other managed care networks aggressively recruiting primary care physicians will further increase the shortage of primary care providers in rural areas.

2. Under universal access, the number of insured residents and, thus, the demand for health services, will be lower than under universal coverage. This level of demand may not provide the minimum level of support for as many health care professionals and/or facilities in rural areas as compared to universal coverage.

3. It is not clear how the insurance sector will be affected by changes in the insurance delivery system caused by this bill.

I. **Compared to the continuation of current trends, will the level of economic activity of rural health businesses be enhanced, diminished or unaffected if the bill is enacted as introduced?**

S 1770 HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993

EXPERT PANEL CONSENSUS: IN THE LONG RUN, THE AMOUNT OF AGGREGATE ECONOMIC ACTIVITY IN THE RURAL HEALTH SECTOR WILL DECREASE.

RATIONALE:

This bill provides for universal coverage through individual mandates. Coupled with subsidies for low income families, this increases the demand for health care in rural areas. However, it has few provisions for ensuring an adequate supply of health care professionals in rural areas. The supply enhancing components of this bill will not overcome the market forces described above, and the consequences will be a reduction in the level of economic activity in the rural health sector.

Considerations which would enhance the supply of rural health care professional include:

1. Tax credits would be available for physicians, physician assistants and nurse practitioners who practice in under-served areas;

2. National Health Services Corps loan payments would be excluded from gross income;

3. National Health Service Corp funding would be increased;

4. Medical equipment purchased for rural practice would be tax deductible;

5. Interest on medical profession student loans for professionals in rural communities would be tax deductible;

6. Two grant demonstration project programs would seek ways to get more medical students in primary care practices; and

7. Grant support would be increased slightly for family Medicare, general internal medicine, general pediatrics, physician assistants and nurse practitioners.

Considerations which would enhance rural health care facilities include:

1. Grants would be available to create and enhance community-based primary health care;

2. Grants to federally qualified health centers would expand services to medically under-served populations;

3. Support would be available for Rural Emergency Access Care Hospitals to replace rural hospitals in danger of closing;

4. Creation or enhancement of air medical transport systems would be provided for medical emergencies in rural areas;

5. Universal coverage would enhance revenues for rural services and should result in increased investment in rural health facilities; and

6. Grants would be available for the purposes of establishing and operating rural health networks.

CONCERNS:

1. This bill would be improved if medical professional supply expanding features were included. An expanded supply is needed to overcome the current market forces described above.

2. It is not clear how the insurance sector will be affected by changes in the insurance delivery system caused by this bill.

II. **Compared to the continuation of current trends, will the level of economic activity of the rural health sector, relative to the urban health sector be enhanced, diminished or unaffected if this legislation is enacted as introduced?**

HR 3600 HEALTH SECURITY ACT OF 1993

EXPERT PANEL CONSENSUS: THE BILL WILL INCREASE THE LEVEL OF ECONOMIC ACTIVITY OF RURAL HEALTH CARE BUSINESSES RELATIVE TO THEIR URBAN COUNTERPARTS, ALTHOUGH SOME RURAL HEALTH CARE BUSINESSES WILL BE UNABLE TO SUCCESSFULLY MAKE THE TRANSITION.

RATIONALE:

1. Universal coverage could lead to the achievement of sufficient economies of size in the rural health care sector to justify a greater variety and level of health care services in rural areas.

2. Since rural areas have a higher proportion of elderly and poor, demand for health services will increase, in absolute terms and proportionately, due to the proposal's benefits targeted at the elderly and poor. (Example: Three such components include the new grant program for home and community-based services for the disabled, expansion of nursing home coverage and the provision to cover prescription drugs for Medicare patients.)

3. Increased funds for investment in facilities, increased funds for programs impacting the elderly and the poor, and use of telemedicine techniques could increase the demand for health services in rural areas. This, in turn, could lead to the provision of more health services in rural areas.

CONCERN:

1. Until supply enhancing programs become effective, reduced numbers of rural health professionals could lead to permanent shifts in the health care purchasing behavior of rural residents, toward metro health delivery. This shift in behavior could include reduced purchases of other health care services, such as drugs, hospital services, long term care, etc. These behavior patterns could lead to insufficient demand for health care providers in rural areas, in the long term when supplies are enhanced.

II. Compared to the continuation of current trends, will the level of economic activity of the rural health sector, relative to the urban health sector be enhanced, diminished or unaffected if this legislation is enacted as introduced?

HR 3222 THE MANAGED COMPETITION ACT OF 1993

EXPERT PANEL CONSENSUS: THE BILL WILL INCREASE THE LEVEL OF ECONOMIC ACTIVITY IN SOME RURAL COMMUNITIES, BUT IN OTHERS THE SUPPLY ENHANCING FEATURES MAY COME TOO LATE TO OFFSET FOR THE INCREASED COMPETITION FROM URBAN HEALTH SYSTEMS.

RATIONALE:

1. Increased demand for health services due to universal access could lead to the achievement of sufficient economies of size in the health care sectors of some rural communities to justify a greater variety and level of health care services.

2. Given increased funds, flexibility, and improved technology, provision of health services and facilities could be improved and more rural residents could use them.

3. In communities where health care services are marginally economical, the increased demand will be insufficient to overcome the increased competition with urban health systems.

CONCERNS:

1. In the transitional period, reduced numbers of rural health professionals could lead to permanent shifts in the health care purchasing behavior of non-metro residents toward metro health delivery. This shift in behavior could include reduced purchases of other health care services such as drugs, hospital services, long term care, etc. These behavior patterns could lead to insufficient demand to induce health care providers to return to rural areas when supplies are enhanced.

2. This bill caps the growth in Medicare expenditures. This may widen the payment gap between Medicare and private payers. Rural facilities with a large share of Medicare business may find it difficult to retain health professionals as they would have a financial incentive to move to urban areas which have a smaller share of Medicare patients.

II. **Compared to the continuation of current trends, will the level of economic activity of the rural health sector, relative to the urban health sector be enhanced, diminished or unaffected if this legislation is enacted as introduced?**

S 1770 THE HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993

EXPERT PANEL CONSENSUS: THE BILL DOES NOT CONTAIN FEATURES TO ENHANCE THE SUPPLY OF PRIMARY CARE PROFESSIONALS, THUS RURAL RESIDENTS MAY BE FORCED TO GO TO URBAN AREAS FOR HEALTH SERVICES.

RATIONALE:

1. Universal health insurance coverage will increase the revenues for health service providers. This is especially true in rural areas where the level of uncompensated care is disproportionately high. The increased revenue could lead to economies of size in the rural health care sector sufficient to justify a greater variety and level of health care services in the rural health care sector.

CONCERNS:

1. The market forces which are currently enticing rural health care providers to join urban health systems will continue. The shortage of rural health care providers will become ever greater and rural residents will have to go to health care providers in urban areas for more and more health services. Since the plan contains little incentive to increase the supply of primary care providers, the proportion of rural residents seeking health services in urban areas will increase.

2. This bill caps the growth in Medicare expenditures. This may widen the payment gap between Medicare and private payers. Rural facilities with a large share of Medicare business may find it difficult to retain health professionals as they would have a financial incentive to move to urban areas which have a smaller share of Medicare patients.

CRITICAL COMPONENT II: RURAL NON-HEALTH BUSINESSES

The impact of each of these plans on rural non-health businesses depends on the distribution of rural firms by type of industry, size of firms, wage levels, and current insurance status. Although current insurance status is not known, we do know that small businesses are less likely than large businesses to provide insurance for their employees (Urban Institute study) and that a larger proportion of businesses in rural areas are small (Miller, 1993). We also know that a lower percentage of rural workers than urban workers are insured through their employer or union (Porterfield, 1993). In addition, rural jobs in many industrial sectors, have very low average wages relative to urban jobs in the same sectors (Bernat, 1994).

I. **Compared to a continuation of current trends, will the economic viability of rural non-health businesses be enhanced, be diminished, or remain unchanged if the bill is enacted as introduced?**

HR 3600 HEALTH SECURITY ACT OF 1993[1]

EXPERT PANEL CONSENSUS: THE ECONOMIC VIABILITY OF MOST RURAL NON-HEALTH BUSINESSES WILL BE UNCHANGED.

RATIONALE: Businesses are in a position to pass along increased costs to workers

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[1] The financing mechanisms underpinning HR 3600 include premiums (subsidies) to be paid (received) by businesses and households, "savings" from Medicare reductions, changes in the tax code, etc. However, the analysis of this particular question includes only premiums, subsidies, and changes in the tax code tied directly to the business sector. Specifically, this analysis reflects only the following considerations:

- The basic requirement that employers pay about 80% of the average premium cost for all employees who work at least 40 hours/month, with total employer cost not to exceed 7.9% of payroll.
- Modification of the above requirement for firms with low-wage employees and with fewer than 75 employees. The lowest cap is 3.5% of payroll for firms with fewer than 25 FTE employees and average annual wages per FTE of not more than $12,000.
- 1% payroll tax for corporate alliances.
- The self-employed would pay 7.9% of self-employment, income or the employer portion of the average premium, whichever was lower. This contribution would be tax deductible.

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because most continue to work even if take-home pay declines -- at least within some reasonable limit. Several studies cited in the CBO analysis of HR 3600 provide empirical evidence to support this scenario. For example, one study found that virtually all of the cost of federal and state mandates for childbirth coverage was passed along to workers in the form of lower real wages. In rural areas, where alternative employment opportunities are limited, it becomes even easier for businesses to pass along to workers any cost increases associated with health insurance. Additionally, to the extent that the rural work force is less likely to be influenced by organized labor unions, it becomes easier to pass along cost increase to employees. Furthermore, some rural business do not have any nearby competitors, e.g., the only grocery store in an isolated rural community. This position of a "local monopolist" enables the business to pass along some increased costs in the form of higher prices, thereby helping to maintain previous profit levels.

However, not all rural businesses are in a position to pass along to their employees any increase in health insurance premiums -- especially in the short run. According to additional analysis by RUPRI of Loprest's study, the "average" annual cost to the non-metropolitan employer would be $32 per worker. Firms could adjust to this at least one of three ways, or some combination thereof: raising prices; decreasing profits; or reducing their work force. It is critical to note that the $32 is an average, and masks considerable variation among firms and industries. Indeed, some firms will see significant reductions in their health insurance costs. The variation in the magnitude of the changes depends on a number of factors, including variations among firms/industries in (a) wage levels (b) size of work force (c) labor-intensity of the firm/industry (d) whether or not insurance is currently being provided and (e) the age and health status of the work force and the risk associated with the workplace environment. Those firms -- rural and urban -- that will likely have the most difficulty in adjusting to HR 3600 are:

* Low-wage firms/industries not currently providing insurance, or providing only a marginal benefit package. Because of minimum wage legislation, these firms/industries will have difficulty passing along increased costs in the form of lower wages. However, HR 3600 does provide temporary subsidies for lower-wage firms(regardless of whether or not they are currently providing insurance).

* Smaller firms not currently providing insurance, or providing only a marginal benefit package. In general, smaller firms may not have the flexibility and financial cushion to absorb the initial impact of an employer mandate. However, HR 3600 does provide temporary subsidies for firms with 75 or fewer employees (regardless of whether or not they are currently providing insurance).

* Firms/industries that are labor intensive and are not currently providing insurance, or are providing only a marginal benefit package. Obviously, if labor costs are a relatively large share of the businesses total costs, there is

a larger adjustment process for the firm than if that is not the case.

* Firms/industries that have relatively young and healthy workers in low-risk occupations. Moving from experience-based rating to community-based rating will cause firms/industries with young and healthy work forces involved in low-risk occupations to effectively subsidize those firms/industries whose workers do not have these characteristics.

An additional group that may have some difficulty with short-term adjustments are self-employed business people, including farmers and ranchers, who do not currently have health insurance and would now be required to purchase insurance. However, those who are self-employed and already have insurance would be significant beneficiaries of HR 3600 for at least two reasons. First, the insurance premium would be fully deductible (in contrast to the current deductibility of only 25% of the premium). Second, the purchasing alliances generate "economies of scale" in purchasing that do not currently exist for self-employed. This latter point, is, indeed, an important positive consideration for all small businesses, given that estimates of administrative expenses for small employers run between 25 and 40 percent of the premium costs.

Finally, the rural business sector will benefit from the "portability" of insurance coverage that is guaranteed in HR 3600. Specifically, this will lead to greater labor mobility which will provide businesses with an enlarged labor pool.

CONCERNS:

1. The biggest concern is for that portion of the rural business sector that may have particular difficulty adjusting to employer mandates. These firms are likely to have the following characteristics: low wage; small; labor-intensive; not currently providing health insurance; and those employing young, healthy workers in low-risk occupations. The subsidies in HR 3600 are effective in reducing the burden for low-wage workers and small firms; and the payroll cap also reduces the burden for firms that rely heavily on low-wage workers. However, more meaningful criteria for subsidies may be the proportion of the firm's operating cost that are attributed to labor costs. In addition to reconsidering the criteria for granting subsidies and capping the payroll "tax", consideration could be given to a phased-in approach. For example, firms that do not currently provide insurance, could be given a graduated requirement, e.g., extending coverage to 10% of their work force in the first year, an additional 20% of their work force the second year, an additional 30% the third year and the final 40% of their work force in the fourth year; or having the employer share begin at a much lower percentage than the current 80% specified in the legislation, and have the proportion gradually rise to 70% or 80%. Finally, subsidies to those types of firms most in need could be put in place on something other than a "temporary" basis.

2. While most existing businesses will be able to pass along to employees any increased premium costs, the existence of "employer mandates" may stifle the creation of new businesses. There "new starts" are an important part of the job generating capacity of the rural economy.

3. Significant record keeping and paperwork requirements are imposed on the business sector. For example, employers must track the changing "family status" of each employee, at the end of the year the employer must reconcile total premium payments and report to the alliance, complete records must be kept for alliance audits, etc.

4. "Gaming" of the system may become commonplace. For example, employers may try to shift more of their operations to "independent contractors" and subsidies to low-wage businesses may lead to artificially low wages. Such "strategic behaviors", while rational, distort the market place, and are unproductive activities that do not enhance societal well-being.

I. Compared to a continuation of current trends, will the economic viability of rural non-health businesses be enhanced, diminished, or remain unchanged if the bill is enacted as introduced?

HR 3222 MANAGED COMPETITION ACT OF 1993

EXPERT PANEL CONSENSUS: THE ECONOMIC VIABILITY OF RURAL NON-HEALTH BUSINESSES WILL VARY BY BUSINESS TYPE.

Large Business Providing Insurance: *HR 3222 will enhance the economic viability of these rural businesses.*

RATIONALE:

1. Most large businesses now providing insurance would not be affected significantly by HR 3222. These businesses would only be affected by provisions that regulate the setting of premium rates for individual employees, but it is unlikely that their total premium costs would change significantly.

2. Possible short-run increase in income taxes if employer pays a premium that exceeds the reference premium rate. However, CBO estimates that in the long-run employers will reduce premium payments to the reference premium, thus shifting the tax burden to employees.

Large Business Not Providing Insurance: *HR 3222 will diminish the economic viability of these rural businesses, by the amount of administrative costs.*

RATIONALE:

Since there is no employer mandate, but there is a requirement to offer insurance, these employers would incur at least the administrative costs associated with offering insurance.

Small Business Providing Insurance: *HR 3222 will enhance the economic viability of these rural businesses.*

RATIONALE:

1. Under HR 3222 these businesses should experience cost savings because they would be eligible to purchase insurance through the Health Plan Purchasing Cooperatives (HPPCS). It is likely that a large portion of these cost savings will be passed on to employees in the form of higher wages, but the remaining savings could be used to lower product prices, increase employment, or increase profits.

2. Small businesses providing insurance would face similar tax implications as would large firms providing insurance.

CONCERN:

Small employers with a significant number of low-wage workers may decide to eliminate their insurance contribution in response to the premium subsidies contained in the HR 3222. The CBO predicts that employers with workers whose income is below the poverty level will stop contributing to their workers' insurance and raise their wages because the entire cost of the premium would be paid by the federal government. Without a response by the employer, the incentives in the plan would push low-wage employees to firms not paying a portion of the insurance premium.

Small Business Not Providing Insurance: *HR 3222 will diminish the economic viability of these rural businesses, by the amount of administrative costs.*

RATIONALE:

Since there is no employer mandate, but there is a requirement to offer insurance, these employers would incur at least the administrative costs would offering insurance, but the costs of doing this should be minimal because they are required to offer a plan offered through the HPPC.

Self-Employed With Insurance: *HR 3222 will enhance the economic viability of these*

rural businesses.

RATIONALE:

1. Some costs savings due to increased tax deductibility of health insurance premiums would benefit self-employed persons.

2. It is likely that health insurance premiums will be reduced due to community rating.

Self-Employed Without Insurance: *HR 3222 will leave unchanged or possibly enhance the economic viability of these rural businesses.*

RATIONALE:

1. There is no employer or individual mandate in HR 3222.

2. HR 3222 will increase the health insurance options available to self-employed individuals.

I. **Compared to a continuation of current trends, will the economic viability of rural non-health businesses be enhanced, be diminished, or remain unchanged if the bill is enacted as introduced?**

S 1770 HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993

EXPERT PANEL CONSENSUS: THE ECONOMIC VIABILITY OF RURAL NON-HEALTH BUSINESSES WILL VARY BY BUSINESS TYPE.

Large Businesses Providing Insurance: *S 1770 will enhance the economic viability of these rural businesses.*

RATIONALE:

1. Since there is no employer mandate, businesses currently offering health insurance will not be significantly affected by the S 1770 plan.

2. Premiums may decline due to community rating. However, since large firms are ineligible to contract for health insurance through small employer purchasing groups, savings may come only if larger employers contract together for insurance services.

CONCERNS:

1. Businesses currently providing health insurance coverage to their employees may discontinue their contribution given the individual mandate in this plan. Wages may increase to compensate employees for reduced benefits. If all savings are not passed on to employees, remaining savings may be used to lower product prices, increase employment, or increase profits.

2. Alternatively, if employers continue to pay health insurance premiums, these will likely fall to the applicable dollar limit (the average cost of the lowest priced one-half of qualified health plans offered in the HCCA).

Large Businesses Not Providing Insurance: *S 1770 would diminish the economic viability of these rural businesses by the amount of the administrative costs.*

RATIONALE:

1. Since there is no employer mandate, but there is a requirement to offer insurance, these businesses would incur at least the administrative costs associated with offering insurance and collecting premiums through payroll deduction for those employees who decide to purchase insurance through the firm.

2. Large businesses must offer both standard benefits and catastrophic plan options which may complicate administration of benefits.

CONCERN:

1. Businesses have little incentive to find a low-cost plan. Their incentive is to find a plan which minimizes administrative rather than health care costs.

Small Businesses Providing Insurance: *S 1770 would enhance the economic viability of these rural businesses.*

RATIONALE:

1. S 1770 allows small employers to either join a purchasing group or offer a standard or catastrophic benefits coverage qualified health plan. Either option should lead to reduced health insurance premiums.

2. As under HR 3222, it is likely that a large portion of these cost savings will be passed on to employees in the form of higher wages, but the savings could also be used to lower product prices, increase employment, or increase profits.

CONCERN:

1. Small businesses may also choose to reduce or eliminate health insurance benefits and provide employees with monetary compensation to make their own insurance choices.

Small Business Not Providing Insurance: *S 1770 would diminish the economic viability of these rural businesses by the amount of the administrative costs.*

RATIONALE:

1. Since there is no employer mandate, but there is a requirement to offer insurance, these businesses would incur at least the administrative costs associated with offering insurance and collecting premiums through payroll deduction for those employees who decide to purchase insurance through the firm.

2. Because S 1770 allows small employers to either join a purchasing group or offer a standard or catastrophic benefits coverage qualified health plan, administrative costs should be minimal.

CONCERN:

1. Again, businesses have little incentive to find a low-cost plan. Their incentive is to find a plan which minimizes administrative rather than health care costs.

Self-Employed With Insurance: *S 1770 would enhance the economic viability of these rural businesses.*

RATIONALE:

1. Individuals are allowed to fully deduct their health insurance premiums to the applicable dollar limit.

Self-Employed Without Insurance: *S 1770 would diminish the economic viability of these rural businesses.*

RATIONALE:

1. Although these individuals would now have access to lower-cost health insurance, they would be required to increase business costs by purchasing either a catastrophic or standard benefits plan.

II. **Compared to urban non-health businesses, will the economic viability of rural non-health businesses be enhanced, diminished, or remain unchanged if the bill is enacted as introduced?**

HR 3600 HEALTH SECURITY ACT

EXPERT PANEL CONSENSUS: THE ECONOMIC VIABILITY OF RURAL NON-HEALTH BUSINESSES WILL REMAIN UNCHANGED, RELATIVE TO URBAN NON-HEALTH BUSINESSES.

RATIONALE:

The Loprest study noted earlier suggested the "average" annual cost to the non-metropolitan employer would be $32 per worker. The comparable figure per worker in metropolitan areas is virtually the same, i.e., $34. While there are features of HR 3600 that are especially beneficial to non-metropolitan areas, there are other features where the reverse is true. Several of the critical features that have the net effect of off setting each other follow:

* HR 3600 places a 1% payroll tax on corporate alliances (of 5,000 or more employees), and such corporate alliances are much more likely to be located in urban areas.

* 45% of non-metropolitan establishments have fewer than 100 employees compared to 38% of metropolitan establishments. On balance, smaller firms will likely have more difficulty adjusting to "employer mandates" than will larger firm, even when subsidies are available to smaller establishments. For example, in 1989, over 94%of firms with 25 or more employees offered health insurance, but only 39% of firms with fewer than 25 employees did so (CBO, p. 54).

* Earnings per worker (in 1992) were substantially less in non- metropolitan areas than in metropolitan areas. This held across all regions of the US, and across all industry types. Low wage firms/industries are more likely to have difficulties passing along increased health insurance costs, even when subsidies are targeted to such firms.

* Non-metropolitan areas have a higher proportion of self-employed workers than do metropolitan areas (11.0% compared to 9.5%). Self-employed workers are likely to be beneficiaries of HR 3600 due to the change in the tax code.

* Additionally, the community rating provision in HR 3600 has the potential for being beneficial to many rural businesses and industries. Specifically, firms that employ older and less healthy workers in relatively risky occupations would benefit more than would firms employing younger and

more healthy workers in lower risk occupations. Many rural firms are more likely to fall into the former, rather than the latter category. For example, a somewhat larger proportion of the non-metropolitan work force than the metropolitan work force is over 45 years old (38% compared to 36.0%); and is more likely to be employed in the "goods-producing" sector includes the relatively more hazardous occupation of agriculture, forestry, fishing manufacturing, construction, and mining.

* Although the rural business sector has more low-wage firms, it may still be somewhat easier to pass along increased premium costs in urban costs in rural areas than in urban areas. First, rural businesses -- at least those who serve local markets -- may have fewer competitors, than in urban areas, and can more easily raise prices. Second, alternative employment opportunities and the influence of unionization are of a lesser magnitude in rural than in urban areas. This may result in less resistance to passing along to workers any increase in health premiums.

II. **Compared to urban non-health businesses, will the economic viability of rural non-health businesses be enhanced, be diminished, or remain unchanged if the bill is enacted as introduced?**

HR 3222 MANAGED COMPETITION ACT OF 1993

EXPERT PANEL CONSENSUS: THE ECONOMIC VIABILITY OF RURAL NON-HEALTH BUSINESSES WILL REMAIN UNCHANGED RELATIVE TO URBAN NON-HEALTH BUSINESSES.

RATIONALE:

HR 3222 would not have a significant direct impact on the non-health business sector in either rural on urban areas. Hence, little differential impact can be expected.

II. **Compared to urban non-health businesses, will the economic viability of rural non-health business be enhanced, be diminished, or remain unchanged if the bill is enacted as introduced?**

S 1770 ACCESS REFORM TODAY ACT OF 1993

EXPERT PANEL CONSENSUS: THE ECONOMIC VIABILITY OF RURAL NON-HEALTH BUSINESSES WILL REMAIN UNCHANGED RELATIVE TO URBAN NON-HEALTH BUSINESSES.

RATIONALE:

S 1770 would not have a significant direct impact on the non-health business sector in either rural or urban areas. Hence, little differential impact can be expected.

CRITICAL COMPONENT III: RURAL FAMILIES

I. **Compared to a continuation of current trends, will the economic status of rural families be enhanced, diminished, or unchanged if this bill is enacted as introduced?**

HR 3600 HEALTH SECURITY ACT

EXPERT PANEL CONSENSUS: ON BALANCE, THE SHORT RUN IMPACT ON THE ECONOMIC STATUS OF RURAL FAMILIES IS UNCLEAR. IN THE LONG RUN, THE ECONOMIC STATUS OF RURAL FAMILIES IS ENHANCED.

RATIONALE:

HR 3600 will have negative net wage and employment effects during the three to five year transition. Families with employees of small and low wage firms may be particularly vulnerable. The economic status of rural families is enhanced positively during the transition and long run by the combination of increased subsidies to low income families, subsidies to small business, increased tax deductibility for self-employed, direct and indirect effects of community rating on premiums, and reduction in uncompensated care.

* EMPLOYER MANDATES: While overall well being may remain unchanged or improve during the transition, employer mandates would lower net wage income of rural workers during the three to five year transition period, according to a RUPRI analysis of outside studies(1). This impact results from two separate effects. First, employees collectively pay an increased portion of premiums out of pocket (on average). Second, the employer mandate increases the employer's payment on behalf of workers (on average), and a portion of that payment is passed on to workers. According to the RUPRI analysis of the Loprest et al. study (1994), rural workers would lose $166 per year in net income (see Table 1). Job loss is estimated to be 81 thousand jobs. These negative wage and income impacts may be offset by increased access and coverage during the transition.

* LOW INCOME FAMILIES: According to CBO, Medicaid payments would be substantially less than under current law, however, these reductions are more than off set by increased assistance to low income families.

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(1) This conclusion is based on an analysis of two studies of the impacts of the Clinton plan's employer mandates: (1) the Aaron-Bosworth study cited in CBO (1994, p. 55), and (2) the Loprest et al. (1994) study.

Table 1 Employer mandates and changes in net pay (Luprest estimates)

Industry	EMPLOYER COST (billions of dollars)		Change in net pay ($/worker)	Change in employer share ($/worker)	PERCENTAGE DISTRIBUTION OF WORKERS					
	Current	Mandated Reform			Large Metro	Other Metro	Nonmetro adjacent	Nonmetro not adjacent	Metro	Nonmetro
Agriculture, forestry, fishing	$109	$134	($286)	($54)	5.8%	9.0%	14.7%	15.3%	7.1%	15.0%
Manufacturing, Durables	$276	$253	$195	$37	10.7%	12.0%	14.5%	11.4%	11.2%	13.0%
Manufacturing, Nondurables	$161	$164	($35)	($7)	7.0%	8.7%	13.2%	9.7%	7.7%	11.5%
Transportation, communication, utilities	$188	$167	$260	$50	8.5%	7.4%	6.7%	7.5%	8.1%	7.1%
Wholesale trade	$74	$88	($309)	($59)	5.1%	4.2%	2.9%	3.3%	4.7%	3.1%
Retail trade	$137	$201	($369)	($70)	15.9%	18.2%	16.9%	18.0%	16.9%	17.4%
Finance, insurance, real estate	$115	$142	($370)	($71)	8.5%	6.4%	4.5%	5.2%	7.7%	4.6%
Services	$470	$561	($254)	($48)	38.4%	34.0%	26.7%	29.5%	36.7%	28.1%
TOTAL WORKERS	$1530	$1710			100%	100%	100%	100%	100%	100%
Average reduction in net pay ($per worker)			($176)		($180)	($176)	($157)	($176)	($178)	($166)
Average impact on employers ($per worker)				($34)	($34)	($34)	($30)	($34)	($34)	($32)

Table 2. Job loss from employer mandates under the Clinton plan by region

	Large Metro	Other metro	Nonmetro adjacent	Nonmetro nonadjacent	Total
Number of workers (in thousands)					
Traded	9,444	8,373	3,812	3,247	24,876
Non-traded	49,481	31,172	7,367	7,851	95,876
Total private workers	58,925	39,550	11,179	11,098	120,752
Number of jobs lost under mandate (in thousands)					
Traded sectors	22.4	19.9	9.0	7.7	59.0
Non-traded sectors	227.1	143.1	33.8	36.0	440.0
Total job loss	249.5	162.9	42.9	43.7	499.0
Impact on population in geographic area					
Total population	113,807	86,631	28,592	25,885	254,915
Job loss per 1000 persons	2.19	1.88	1.50	1.69	1.96

SOURCE: RUPRI analysis of data from (a) Loprest et al. (1994) and (b) REMI forecast of workers by geographic area, 1994.

Under HR 3600, Medicaid recipients receiving cash retain Medicaid coverage but enroll in health plans through alliances. The growth rate of per capita payments to regional alliances would be limited. Medicaid recipients receiving noncash benefits would enroll in plans through alliances and most would presumably qualify for Federal subsidies to families.

Families with adjusted gross income of less the $40,000 would qualify for income related premium caps. Premiums would also be limited for those with income less than 250 percent of poverty.

Therefore, families currently qualifying for Medicaid may experience a shift in health expenditures from the government to personal income sources. However, other low income and unemployed families not qualifying for Medicaid may experience a shift in personal health expenditures from personal sources to the government.

- SELF-EMPLOYED FAMILIES: HR 3600 increases the tax deductibility of health premiums for self-employed families from 25 percent to 100 percent for the standard benefit package. Adoption of a national standard benefit package may improve the coverage of self-employed families with insurance at the margin. Self-employed families with small businesses are also likely to benefit from access to community rated premiums, premium caps and assistance to employers and families. Self-employed small businesses tend to make up a higher percentage of the rural economic base.

- FAMILIES EMPLOYED BY A SMALL BUSINESS: HR 3600 mandates that employers cover 80 percent of the cost of employee premiums for the national standard benefit package.

Low wage families employed by small businesses that currently provide no insurance or low levels of contributions toward health insurance will experience an increase in insurance coverage and a shift in health premiums from their personal family earnings to their employers. In turn employers will pass a portion of this cost back to employees in the form of lower wages and employment. Adoption of a national standard benefit package may also improve the coverage of these families at the margin. However, these families will also likely observe a negative adjustment in take home earnings and employment opportunities as employers attempt to recoup most of the employer mandate impact by passing a substantial cost of mandated premiums back to employees.

Higher income families presently employed by small businesses that purchase a superior benefit package may experience a reduction in benefits and a shift in health premiums from their employer to their personal family earnings. This may occur if employers purchasing superior benefits attempt to reduce costs by moving to standard benefit packages and the employer mandated shares, in the form of wage increases.

In addition, families employed by small businesses are likely to benefit from access to community rated premiums, premium caps and increased government assistance to employers and families. These provisions will mitigate some of the wage impacts stemming from employer mandates.

* FAMILIES EMPLOYED BY A LARGE BUSINESS: The direction of change in health expenditures paid out of family earnings for employees of large business is similar to those employed by small businesses. In other words, families currently purchasing most of their own insurance will see some shift to their employer. Other families for whom the employer is currently purchasing a wide range of health benefits may see a reduction in benefits and a shift in health costs to their personal earnings. Over 94 percent of the firms with 25 or more employees offered health insurance to their employees in 1989 (CBO, 1991). Therefore a greater proportion of families employed by large businesses are likely to be in the second group and large businesses represent a disproportionate share of urban business community.

In addition, families employed by large firms will not be impacted by community rating and will not qualify for assistance to small employers. Firms with over 5000 employees may choose to operate their own alliance and therefore will be subject to an additional 1 percent payroll tax. Employees of large firms may still indirectly benefit from low wage assistance to employers and to families if premium caps become binding for the firm.

* OLDER FAMILIES: The impact of health care reform on the elderly population is of particular concern because of the higher percentage of elderly residents in rural areas. Approximately 8.4 million rural residents are over age 65 (Table 3) and this represents a higher share of the rural population (15.3 percent) than does the share of elderly residents in urban areas (12.3 percent).

Table 3.
Metro and non-metro population, by age, 1994

Area of residence	Total Pop.	Pop. Age 65 +	Pop. < Age 65
	(Millions of persons)		
Metro	202.0	24.9	177.1
Non-metro	54.0	8.3	45.7
	(Percentage of total)		
Metro	100.0%	12.3%	87.7%
Non-metro	100.0%	15.3%	84.7%

SOURCE: RUPRI Rural Baseline, June 1994.
NOTES: Metro areas include core counties of large metro areas, as well as other metro counties. Non-metro areas include non-metro counties adjacent to metro areas, as well as non-metro areas not adjacent to metro areas.

Selected provisions of the HR 3600 are aimed at non-elderly families. In particular, the two federal health care programs that have the largest impact on elderly families -- Medicaid and Medicare -- are largely left intact for elderly persons. There are four major provisions in the HR 3600 that will impact elderly residents. Given that rural areas have a higher proportion of elderly residents, it is suspected that rural areas will also experience greater impacts by these provisions which affect rural elderly residents:

(1) Prescription drug coverage under Medicare

- HR 3600 would cover the cost of prescription drugs for outpatients, as part of Medicare's Supplementary Medical Insurance (SMI) program. Prescription drugs would be covered after payment of a $250 annual deductible, with a 20 percent co-payment by the elderly, and an annual out-of-pocket limit of $1,000. In anticipation of potential increases in the demand for prescription drugs, the HR 3600 also contains a number of provisions to restrain program expenditures, including limits on payments to pharmacies and rebates from drug companies to Medicare. The CBO projects that this new coverage would add $73 billion to Medicare expenditures from 1996 to 2000.

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- Out of pocket payments for prescription drugs account for a significant proportion of expenditures for the elderly.[2] Thus, insurance coverage of prescription drugs could be important for many elderly families. However, the CBO estimates that 25 percent of the new expenditures for prescription drug coverage will be financed by an $11 per month increase in Medicare Part B premiums, while the rest will be financed by general revenues. Thus, in the aggregate, elderly families will see a decrease in out of pocket health expenditures after netting out the additional premium charges.

(2) **New state-federal program for long-term care**

- HR 3600 proposes that a new federal program be created to provide grants to states for setting up a home health program to provide home health care expenditures for elderly and disabled families. State governments would set up programs to assess the home health care needs of disabled persons and to set up a care plan for them if they qualify for the program. Recipients with incomes below 150 percent of the poverty line would receive these services for free, while recipients with incomes above that amount would be responsible for co-payments that increase with income. The maximum co-payment would be 25 percent for families with incomes at or above 250 percent of the poverty line.

- Expenditures on long-term care, especially nursing home care, are the largest out of pocket health care expenditure for elderly families. However, most of these funds are used to pay for nursing home care because of the lack of insurance for home health care and coverage problems in the home health care market.

Because home health care is cheaper than nursing home care, it is hoped that this new program will lessen the demand for nursing home care and lower expenditures for nursing home care. However, available research does not support this hypothesis (Wiener and Harris, 1993). Instead, subsidies for home health care are likely to encourage an increase in demand for home health care that is likely to outstrip the savings in nursing home expenditures (Coughlin, Liu, and McBride, 1992). In fact, the CBO predicts that the program will increase federal expenditures by $61 billion from 1996-2000.

- The federal grants for home health programs will be based on average per capita income in a state and state governments will be required to provide matching funds for these expenditures. Thus, the impact of this program on elderly persons will depend heavily on decisions made about funding,

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[2]Daniel R. Waldo and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States, 1977-84," Health Care Financing Review 6(1): 1-29, Fall 1984.

eligibility, and service delivery at the state level.

(3) **Other provisions impacting long-term care**

- Three minor changes in Medicaid provisions would increase the number of persons eligible for Medicaid coverage for nursing home expenditures. These Include:(1) an increase in the amount of assets single persons can exclude when calculating eligibility (from $2,000 to $12,000), (2) a requirement that states grant eligibility to elderly persons who are eligible if their nursing home expenditures were deducted from their income, and (3) an increase in the personal needs allowance for nursing home residents from $30 to $50. In addition, HR 3600 would institute a number of changes designed to increase the number of persons that would purchase private long-term care insurance.

(4) **Early Retiree Health Coverage**

- HR 3600 requires employers to provide health insurance for early retirees under age 65. Medicare would continue to provide health insurance coverage for retired persons age 65 and older. Firms would be required to fund only 20 percent of early retiree coverage, while the federal government would provide subsidies for the remaining portion of the premium under certain circumstances. The out of pocket cost for early retiree insurance would rise for higher income retirees but, middle and lower income retirees would qualify for applicable subsidies. Because this provision could provide a huge financial windfall for some firms, firms would be required to pay a temporary assessment on the savings from this provision, until the year 2000.

- HR 3600 would reduce health benefit payments by employers that face significant costs for early retiree health obligations. It is likely that some portion of these reduced costs will be passed on to workers through higher wages. In addition, economic studies have shown that workers with retiree health coverage are significantly more likely to retire. Thus, it is likely that more workers between age 55 to 64 will decide to retire early in response to the incentives included in the HR 3600. The CBO projects that the number of workers that retire between the ages 55 and 64 could increase by between 350,000 and 600,000 in response to this coverage.

(5) Medicare and Medicaid program cuts

- Under HR 3600, the cuts in Medicare are partially financed by higher co-payments and lower increases in reimbursement rates paid to hospitals and other providers. The Medicare cuts are used to finance additional drug benefits and long term care benefits for the disabled. As a result, many retired families would experience increases in health costs from their retirement earnings, while they also gain access to greater benefits.

Reductions in the reimbursement rates paid to providers could significantly impact the access of elderly persons to Medicare related services. However, it should be noted that HR 3600 also contains provisions increasing incentives for primary care providers and limiting the growth of private insurance premiums. The result is that the gap between Medicare and private insurance reimbursement rates will not grow which means the impact of the Medicare programs cuts will be less than otherwise would be expected.

Elderly families with higher incomes (above $90,000 single and $115,000 married) would experience increasing premiums as proposed in HR 3600. While rural families have a higher proportion of senior citizens, urban families have a higher average incomes. A higher percentage of high-income senior citizens live in urban areas according to an analysis of national RUPRI Poll data (1994).

The RUPRI Panel concludes the net health care spending on behalf of seniors and from senior retirement earnings will increase. This occurs in part because existing and new dollars are spread over a greater array of coverage for seniors, however the future Medicare coverage also require a higher level of co-payment from personal income sources of retirees.

CONCERNS:

* Employer mandates may have more unanticipated negative impacts on rural families than is presumed. The RUPRI analysis presumes no rural/urban differentials in average firm size and size effects within industries which may create additional differential rural/urban effects on rural families. Small and low wage businesses are likely to have less flexibility to adjust to employer mandates than larger businesses. The adjustment process might include phased-in targets, training programs, monitoring to identify problems as they develop, and assistance for severely impacted small and low wage businesses and their employees.

* Our conclusions about the impacts on families are predicated on the CBO estimates, which presume that the cost containment mechanisms are successful. A concern develops if the cost containment provisions are not as effective as assumed. This would tend to increase the costs to families which may place the expanded government benefit and subsidy programs at risk.

* Graduated caps on employer mandated premiums based on firm size and wage level provide an incentive for businesses to reorganize into small and/or low wage firms to qualify for subsides to employers.

* Reduction of Medicaid subsidies will reduce the present disincentive to work created by the Medicaid and the relative lack of health care benefits experienced in low wage and part time jobs. Using a graduated approach to

reduce subsides as family income increases may reduce--but not eliminate--the disincentive. However, the net increase in total subsidies to families means more families will receive subsidies--not less.

- Increased incentives for early retirees may create general labor supply problems in some communities and particular shortage problems for certain small businesses in some rural communities.

- There are concems about how regional boundaries of alliances are drawn for community rating purposes and the resulting potential impacts on rural families.

I. **Compared to a continuation of current trends, will the economic status of rural families be enhanced, diminished, or unchanged if this bill is enacted as introduced?**

HR 3222 MANAGED COMPETITION ACT OF 1993

EXPERT PANEL CONSENSUS. THE AVERAGE ECONOMIC STATUS OF RURAL FAMILIES WILL BE LEFT UNCHANGED OR MODERATELY ENHANCED.

RATIONALE:

The impact of the Cooper plan on rural areas depends on the economic and demographic characteristics of persons in rural areas. Although the proportion insured in rural areas is very similar to the proportion insured in urban areas, the source of current insurance coverage differs in rural areas with rural areas less likely to receive insurance through their employer. We also know that a higher proportion of rural persons are over age 65, that rural workers are more likely to work for small employers, and to have lower incomes. Thus, it is important to look at the Cooper plan's differential impact on these types of families:

1) Insured families

On average, premiums for insured workers should decline slightly, in response to decreases in the amount of uncompensated care. However, at the micro level, individual premiums could increase or decrease significantly. The exact change in a family's insurance premium will depend on their characteristics, especially:

- age of workers The Cooper plan adopts a modified form of community rating, allowing for adjustments for age. Despite this fact, it is likely the age rating of current insurance policies will differ from the policies adopted under the Cooper plan.

- current premium based on the experience rating of the business Since

experience rating is used to calculate most current insurance premiums, a shift to community rating should increase the premiums of firms with relatively healthy workers and decrease the premiums of firms with relatively unhealthy workers.

- size of employer Current insurance premiums are now heavily determined by the size of the firm. Community rating will do away with this distinction, increasing premiums for larger firms and decreasing them for smaller firms.

- family income The subsidy structure in the Cooper plan will mean that premiums may fall for low-wage workers and their families. Forty percent of rural families will qualify for subsidies under the Cooper plan (Table 3).

Table 4 Insurance and poverty status of metro and non-metro residents, 1990-91

Ratio of income to poverty line	METRO AREAS			NON-METRO AREAS			TOTAL		
	In-sured	Uninsured	Total	In-sured	Uninsured	Total	In-sured	Uninsured	Total
	(Millions of persons)								
Less than 1.0	16.2	7.4	23.7	5.0	2.5	7.5	21.2	9.9	31.1
1.0-1.49	9.0	4.7	13.7	3.8	1.8	5.5	12.8	6.4	19.2
1.5-1.99	10.8	3.6	14.4	4.5	1.1	5.6	15.3	4.8	20.0
2.0-2.49	12.1	2.9	15.1	4.7	0.7	5.4	16.8	3.6	20.5
2.5 or higher	96.8	8.3	105.1	20.6	1.6	22.2	117.4	9.9	127.3
TOTAL	144.9	27.0	171.9	38.6	7.6	46.2	183.5	34.6	218.2
	(Percentage of total)								
Less than 1.0	11.2%	27.5%	13.8%	12.9%	32.4%	16.1%	11.6%	28.6%	14.3%
1.0-1.49	6.2%	17.3%	8.0%	9.8%	23.0%	12.0%	7.0%	18.6%	8.8%
1.5-1.99	7.4%	13.5%	8.4%	11.7%	14.9%	12.2%	8.3%	13.8%	9.2%
2.0-2.49	8.4%	10.9%	8.8%	12.2%	9.1%	11.7%	9.2%	10.5%	9.4%
2.5 or higher	66.8%	30.8%	61.1%	53.4%	20.5%	48.0%	64.0%	28.5%	58.3%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%

SOURCE: RUPRI analysis of Current Population Survey (CPS) data, merged 1991 and 1992 CPS files (to increase rural sample size).

- Since the Cooper plan contains no employer mandates, it will not impact the aggregate level of employment.

- Families with incomes below the poverty line will have the entire premium financed by the federal government, while families with incomes between 100 and 200 percent of the poverty line would receive subsidies.

If currently insured by their employer, these low-income workers will have the incentive to shift to employers that do not pay for insurance because of the dollar-for-dollar reduction in the subsidy for every dollar paid by the employer and the assumption that employers shift a portion of insurance premiums to employees in the form of lower wages. The combination of health care subsidies for low income families and voluntary employer contributions creates a strong incentive for

companies employing low income workers to eliminate health coverage for these workers and pay higher wages.

* Workers with insurance plans that are more costly than the reference plan (the lowest-priced insurance plan) would face increased tax burdens under the Cooper plan. The CBO predicts that employers would respond to the additional excise taxes on these plans by reducing their premium contributions to the reference premium in the long run. Thus, employees would pay the additional amount out-of-pocket with after-tax dollars. Some of these effects could be mitigated if employers offer a cafeteria plan to their employees to cover some of these costs or if employers decide to pay the excise tax and pass the additional burden onto employees at a lower tax rate.

  Self-employed persons will now be able to fully deduct the cost of their insurance premiums from their taxable income. This provision should significantly lower the out of pocket costs of self employed persons.

* The Medicaid program for the non-elderly will be eliminated under the Cooper plan and the Medicaid covered population must seek insurance through the HPPCs. Thus, families that obtain coverage from Medicaid will experience a significant change, including an increased incentive to work since the Medicaid coverage will no longer be linked to being out of the labor force.

* Families that purchase individual health insurance policies directly from insurance companies should experience a significant decline in their premiums, as they will now be able to purchase a policy directly from the HPPC and the premium will be community-rated.

2) Uninsured Families

* These families will now have access to insurance, but the number of families that will actually obtain insurance depends on their family income. The CBO predicts that the most families that obtain insurance will have incomes below 200 percent of the poverty line because these are the only families that will receive subsidies. Families with incomes above 200 percent of the line will be affected by provisions for modified community rating and increases in the deductibility of health insurance premiums for the self insured. However, the CBO concludes that few uninsured persons with incomes above 200 percent of the poverty line would obtain insurance under the Cooper plan.

  Families with incomes below the poverty line will face no additional out of pocket costs, while families above the poverty line will face additional out of pocket costs for insurance premiums. However, total out of pocket costs for health care could drop if these families already have significant out of pocket costs for health care.

3) Elderly families

- The economic status of elderly families will be diminished under the Cooper plan. The plan makes no significant changes in the Medicare program. However, revenues to fund the proposal are obtained by lowering reimbursement rates paid to hospitals and other providers and raising Medicare premiums for high-income beneficiaries. It is likely that these changes will affect the quality of care provided, but will only impact the out of pocket costs for the high-income elderly.

CONCERNS:

- The Cooper plan institutes insurance market reforms (e.g., modified community rating and elimination of pre-existing condition exclusions) but does not achieve universal coverage. We feel that this may encourage some currently insured persons to drop their health insurance coverage. This is because the Cooper plan removes some of the incentives that encourage people to remain insured even if they do not use many health care services.

  Currently, a person without insurance faces two problems if they need health care services. First, their insurance premiums will increase as a result of their health experience. Second, they may be denied coverage for certain conditions under a pre-existing conditions exclusions provision. The Cooper plan institutes community rating and bans the use of pre-existing condition exclusions. Thus, individuals will have the incentive to remain uninsured until the time that they need health care services, since they will not be denied coverage or have their premiums increased at that point. This will result in a situation where only people with health problems will purchase insurance, while the healthy individuals will not (a phenomenon described as "adverse selection"). This will drive community rated premiums even higher. For example, early indications are that some individuals in New York State have dropped coverage as a result of similar provisions.

- Insured workers with family incomes between 100 and 200 percent of the poverty line will face increasing work disincentives as they move up the income scale under the Cooper plan because additional earned income will result in lower insurance premium subsidies. These work disincentives, while substantial, must be weighed against the work disincentives currently built into the structure of the Medicaid program.

- The ability of uninsured families to obtain insurance under the Cooper plan will crucially depend on provisions for the setting of the components of the benefit package. As pointed out by the CBO, the Cooper bill does not identify what is included in the benefit package and specifies that if federal revenues

are not sufficient to pay for the low-income subsidies, that the level of the subsidies will need to be cut back. Since the CBO projects that there will be a serious shortfall in the subsidies, these provisions could cause serious problems and could mean that many persons above the poverty line will not be eligible for subsidies.

I. **Compared to a continuation of current trends, will the economic status of rural families be enhanced, diminished, or unchanged if this bill is enacted as introduced?**

S 1770 HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993

EXPERT PANEL CONSENSUS: ON BALANCE, THE ECONOMIC STATUS OF RURAL FAMILIES WILL BE MODERATELY ENHANCED.

RATIONALE:

The effects of S 1770 are gradually implemented over a ten year period. The non elderly rural families are better off. This overall result occurs due to increased subsides for low income families. These increased subsidies are financed, by reductions in Medicare spending, which means the economic status of the elderly is diminished as a whole. Rural areas have a greater percentage of elderly. However, many of the specific Medicare reductions involve payments to health care providers and higher premiums for higher-income seniors which tend to live in urban areas. Therefore the impacts of the Medicare reductions on rural elderly will be mitigated to some degree. In addition, the plan includes increased tax deductibility for the self-employed, direct and indirect impacts of community rating, reduction in uncompensated care, and universal coverage in the longer term.

* INDIVIDUAL MANDATES: Universal coverage is presumed to be achieved in the long run under this plan. Any individual who is not covered under a qualified health plan or equivalent by 2005 would be required to pay a penalty equal to 20 percent plus the average yearly premium of the local area. There are no employer mandated premiums. However, employers are required to collet premiums and offer health insurance to their employees. Small employers (less than 100 employees) are required to join health plan purchasing cooperatives. As a result, small business employees gain access to community rating and efficiencies of group insurance management.

* LIMITED FULL TAX DEDUCTIBILITY AND MEDICAL SAVINGS ACCOUNTS: S 1770 provides full deductibility for premiums for health plans up to a limit equal to the average cost of the lowest price half of the health plans available in the area. Contributions to a medical savings account would be fully deductible up to an applicable dollar limit if paid by employees; they would be excluded from income if paid by the employer.

- LOW INCOME FAMILIES: S 1770 encourages a shift of low income families from Medicaid programs to approved health plans over several years. It maintains the current Medicaid payments, but caps the future growth to 6 percent per year. Up to 15 percent of those receiving AFDC or SSI benefits may enroll in health plans in each of the first 3 years, and 10 percent more in each succeeding year. In addition, Medicare savings are used to provide new vouchers to low income people. Vouchers become available to households below 90 percent of poverty in 1997. The ratio to poverty is increased by 20 percentage points each year until it reaches 240 percent of poverty in the year 2205. However the rate of increase in this percentage is contingent upon Medicare savings. The amount of the vouchers would be graduated so as to reduce the disincentives for seeking employment.

- OLDER FAMILIES: The proposed cuts in Medicare under S 1770 are financed in part by increasing premiums for higher income seniors and by maintaining the 25 percent share of Part B premiums and reducing payments for outpatient hospital services, elimination of DSH adjustment, elimination of payments for bad debts and increasing the share of co-payments for laboratory and home health services. Proposals for transferring Medicare recipients to approved health plans are to be developed by the Secretary of Health and Human Services.

- FAMILIES PRESENTLY RECEIVING SUPERIOR HEALTH BENEFITS: Under S 1770, limits on tax deductibility will increase the costs for families presently receiving health benefits that are superior or beyond the scope of the standard benefits package. In addition, such benefits paid for by employer above the standard benefit package are to be treated as taxable income. The RUPRI panel concludes the net impact of the reduced deductibility will likely have greater impacts on urban areas.

CONCERNS:

- Timing issues become a concern with Medicare cuts, because the timing gap may have a greater impact on rural areas.

- Graduated subsidies to low income families will reduce--but not eliminate--the present disincentive to work created by the Medicaid program. The net increase in total subsidies means more families will receive assistance rather than less.

- The boundaries for community rating are an important determinate that will affect the premiums of rural people.

II. **Compared to continuation of current trends, will the economic status of rural families relative to the economic status of urban families be enhanced, unchanged, diminished if this bill is enacted as introduced?**

HR 3600 HEALTH SECURITY ACT

EXPERT PANEL CONSENSUS: ON BALANCE, THE ECONOMIC STATUS OF RURAL FAMILIES WILL BE ENHANCED RELATIVE TO THE ECONOMIC STATUS OF URBAN FAMILIES

RATIONALE:

This consensus is supported by RUPRI analyses of the rural/urban industrial mix differentials combined with Loprest studies on effects of employer mandates. The resulting wage decreases and negative employment effects during the transition are smaller for rural areas relative to urban areas. (See Table 1 and 2.) Table 1 shows that rural workers are likely to work for manufacturing firms which will face a decrease in premiums, but much less likely to work for service firms which will face an increase in premiums.

The RUPRI estimated transition effects of the employer mandate on net incomes of rural workers is smaller ($166) than on urban workers ($178). This primarily results from the impact of mandates on rural workers living in non-metro areas adjacent to urban areas. Workers living in non-metro areas not adjacent to metro areas are estimated to face a somewhat higher decrease in net income ($176).

Rural areas have a higher percentage of low-income persons and families self-employed and/or working for small businesses. Thus, rural areas tend to fair better than urban areas (on average) due to a combination of increased subsidies for low income families, subsidies to small business, increased tax deductibility for self-employed, and direct and indirect effects of community rating.

* LOW INCOME FAMILIES: HR 3600 would increase subsidies for low income families. Rural areas possess a higher proportion of low income families below the limits in HR 3600. Subsidy limits for families are those earning less than $40,000 (qualifying for subsidies for the family share of premiums capped at 3.9 percent) and/or families below 250 percent of the poverty line who qualify for subsidies to cover the employer share. Rural areas have lower average income for working age individuals than urban areas (RUPRI Poll, 1994), therefore health spending on behalf of rural families will likely increase more rapidly than urban families due to the net increase in subsidies to families under HR 3600.

* SELF-EMPLOYED FAMILIES: Health insurance premium purchases become less of a burden in low income years for farmers and other self-employed families with highly variable incomes. Compared to the current system where

premiums gradually increase, premiums become a function of annual income under premium caps. However, the standard benefit package received stays constant. Incomes generated in rural areas from agricultural production tends to be more variable than incomes generated by most other industrial sectors. Therefore, rural areas are likely to benefit more from the premium caps, particularly in years when family income may be severely reduced by drought, flood, or natural disasters.

- FAMILIES EMPLOYED BY A SMALL BUSINESS: In 1989, only 39 percent of firms with fewer than 25 employees provided health insurance to employees (CBO, 1991). Therefore, employer mandates are likely to have greater impacts on the small business community and the families of their employees. The rural business community possesses a higher percentage share of small businesses.

  Loprest et al (1994) suggests that 80 percent of the cost of the employer mandate will be shifted to the employees. CBO estimates appear to presume at least this percent will eventually be shifted to households. The RUPRI Expert Panel suggests the ability of the business to pass on the impacts of employer mandates depends upon the unique characteristics of each firm and its market conditions.

  Selected labor market characteristics do vary between rural and urban areas. These differences may or may not translate into a rural differential in the flexibility of small businesses to pass on the impacts of employer mandates to employee families. The degree of adjustment will depend on the demand elasticity-- firms in a highly competitive market will be unable to pass on the impacts of the employer mandate. In other cases, passing the impacts of the mandate on may depend upon whether firms are enabled, sanctioned and encouraged to pass on the full impacts of the employer mandate.

- OLDER FAMILIES: In general, the provisions of HR 3600 are aimed at non-elderly families. Two federal health care programs that have the largest impact on elderly families--Medicaid and Medicare--are largely left intact. Despite this, there are five major provisions in HR 3600 that will impact elderly residents. Given that rural areas have a slightly higher proportion of elderly residents, it may be generally anticipated that rural areas will also be impacted to a greater degree by most of these provisions.

(1) Prescription drug coverage under Medicare.

  In the aggregate, older families will see a decrease in out of pocket health expenditures, after netting out the additional premium charges and additional drug coverage benefits.

(2) New state-federal program for long-term care.

Rural areas, with a higher share of elderly residents, will benefit from this program. however, supply constraints in rural areas may create a situation where rural areas will be less likely to meet the needs of their disabled population.

(3) Other provisions impacting long-term care.

HR 3600 increases the eligibility standards for Medicaid and low income families. This should reduce the burden of long-term care costs on rural elderly families and improve access to long-term care. However, we are concerned that the additional revenues to fund these changes be made available to states to fund these changes.

(4) Early retiree health coverage.

Rural areas have a higher percentage of older age workers between age 55 and 65. Therefore the enhanced early retirement incentives and impacts would affect rural areas more than urban areas.

(5) Medicare program changes.

The direct impact of the Medicare program changes on out of pocket costs of elderly persons is small, except for high-income elderly families. However, the high-income elderly tend to be live in urban areas. Analysis of RUPRI Poll data (1994) show that rural areas contain a lower proportion of high-income elderly. Therefore, it is likely that the higher premiums will not significantly impact rural areas. However, to the extent that Medicare program changes impact the access to medical care for elderly beneficiaries, elderly rural residents could face increased access problems.

CONCERNS:

* EMPLOYER MANDATES: If employer mandates have a more negative impact than anticipated, the negative impacts are more likely to fall on rural families than urban families. If small and low wage business are likely to have less flexibility to adjust to employer mandates than larger businesses, then the impacts on rural areas are understated. Rural areas have a higher percentage of small businesses than urban areas. A rural health care Commission is needed to monitor the transition process to determine if unanticipated impacts occur for small and low wage businesses and their employees.

- HR 3600 cuts Medicare spending but increases long term care benefits for home care and Medicare drug benefits. A rural-urban difference in senior citizen populations is potentially a key rural-urban differential because rural areas have a higher proportion of senior citizens. Timing issues become a concern if Medicare cuts are imposed before additional benefits to the elderly and incentives for primary care providers are provided. This timing gap may impact rural areas more than urban.

- The differential impacts of employer mandates on rural businesses and families of their employees are a concern. The ability and willingness of businesses to pass on the impacts to employees vary depending upon the unique characteristics of each firm. The full extent of the impacts may not be known until the reforms are implemented. In response, policy makers may determine a need for goals and a range of business monitoring, training and adjustment assistance provisions designed to mitigate problems likely to develop and to detect and resolve problems as they arise.

- Early retirement incentives may open up jobs for younger workers and assist businesses in adjusting to the health reforms, but in the longer run will likely reduce the size of the work force. Work force contributions to health care premiums and social security may have to be marginally increased over time as the size of the Work force declines relative to the size of the total population that receives health care benefits. RUPRI baseline projections suggest these concerns are likely to be amplified around 2010, as the baby boom generation nears retirement.

- Uncompensated care is regarded as a much bigger problem among rural health care providers and consumers than in urban areas. Therefore, policies which reduce these current problems will likely impact rural areas more than urban areas. Not addressing these problems will also have greater impacts on rural areas.

II. **Compared to continuation of current trends, will the economic status of rural families relative to the economic status of urban families be enhanced, unchanged, diminished if this bill is enacted as introduced?**

HR 3222 MANAGED COMPETITION ACT OF 1993

EXPERT PANEL CONSENSUS: THE AVERAGE ECONOMIC STATUS OF RURAL FAMILIES WILL BE MODERATELY ENHANCED RELATIVE TO URBAN FAMILIES.

RATIONALE:

This expert panel consensus is based mostly on the disproportionate number of low-income persons and persons working for small businesses in rural areas. These

groups would benefit from subsidies to low-income persons and insurance market reforms. However, many rural insured and uninsured persons would not be affected greatly by provisions in the Cooper plan.

Insured families

- In comparison to urban families, rural families have older heads of household, work for smaller firms, and have slightly lower incomes. Thus, the shift to community rating and the subsidies for low-income families should disproportionately benefit rural families.

- Rural areas are more likely than urban areas to contain small firms. Thus, the impacts of community rating provisions will disproportionately help rural firms. The resulting impact on employer health insurance costs might lead to some employment changes in rural areas.

- Given that a higher percentage of rural families have incomes below 200 percent of the poverty line, the subsidy structure in the Cooper plan should disproportionately help rural residents. However, we have some concerns about the work disincentives inherent in this bill.

- Rural residents with generous health packages that cost more than the reference premium would face an increased tax burden or lower wages under the Cooper plan. In the short run, it may be more difficult for small rural employers to implement cafeteria plans to soften this impact.

- Rural areas contain a higher percentage of self-employed individuals, including agricultural workers. The ability to deduct insurance premiums from taxes should reduce the effective cost of health insurance considerably for the self-employed. Rural families will be relatively enhanced by this feature.

- Rural areas contain a slightly higher (11 percent) proportion of persons covered by Medicaid, as compared to urban areas (10 percent).[3] Thus, rural areas will be disproportionately affected by cuts in the Medicaid program.

- Since rural residents are more likely to purchase insurance directly from insurance companies, the ability to purchase this insurance directly from HPPCs at a community-rated premium should significantly lower their premiums.

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[3]Shirley Porterfield, "Health Insurance in Rural America," RUPRI Policy Brief, October 1993.

Uninsured families

* The incomes of rural residents are lower than urban residents on average. Thus, a higher percentage of rural residents will qualify for subsidies and will become insured under the Cooper plan. However, the Cooper plan is unlikely to provide enough incentives to encourage very many of rural residents with incomes above 200 percent of the poverty line to obtain insurance coverage.

  A larger proportion of rural residents would qualify for the Cooper subsidies based on their income (Table 1). For instance, 70.4 percent of persons without health insurance living in rural areas have incomes below 200 percent of the poverty line, while only 58.3 percent of urban residents with no insurance have incomes below 200 percent of the poverty line. Thus a higher proportion of rural residents would qualify for the Cooper subsidies, compared to residents in urban areas.

* If the revenues under the Cooper plan are not sufficient to pay for low income subsidies, cutbacks in the premium subsidies would impact rural areas and lead to a situation where uninsured rural persons have little incentive to obtain insurance coverage.

Older families

* Rural areas have a higher percentage of residents that are over age 65 (Table 1). Therefore, rural areas will be disproportionately affected by decreases in Medicare payments. Increased Medicare premiums paid by high income families will impact mainly urban families since a higher proportion of elderly families with higher income reside in rural areas.

CONCERNS:

* Although the insurance market reforms should help rural persons working for small firms, the setting of geographic boundaries for health alliances and for the setting of community rated premiums will have important impacts on rural areas. Specifically, if the boundaries are drawn without accounting for the unique characteristics of rural areas, then the insurance premiums of rural families could be adversely affected.

* Rural areas contain a higher proportion of persons covered by Medicaid and Medicare. Thus, rural areas could be impacted more heavily by the cuts in Medicaid and Medicare expenditures. While these cuts have only small impacts on out of pocket spending, the cuts will impact quality of care provided.

II. Compared to continuation of current trends, will the economic status of rural families relative to the economic status of urban families be enhanced, unchanged, diminished if this bill is enacted as introduced?

S 1770 HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993

EXPERT PANEL CONSENSUS: ON BALANCE, THE ECONOMIC STATUS OF RURAL FAMILIES WILL BE MODERATELY ENHANCED RELATIVE TO URBAN FAMILIES.

RATIONALE:

- INDIVIDUAL MANDATES: Rural areas possess a greater share of self-employed and small businesses. A CBO (1991) study shows only 39 percent of the firms with fewer than 25 employees provided health benefits to their employees. Whereas, 94 percent of the firms with 25 or more employees provide health benefits to their employees. Therefore, the benefits of community rating and group management efficiencies of employer based plans will disproportionately benefit rural areas. On the other hand, the community rating proposed under S 1770 is adjusted by age and family type. Therefore the benefits of community rating for rural areas may be less than under other plans because of the higher share of older age cohorts in rural areas.

- LIMITED FULL TAX DEDUCTIBILITY AND MEDICAL SAVINGS ACCOUNTS: Rural areas possess a higher share of self-employed and individual insurance purchasers that will benefit from uniform tax deductibility.

- LOW INCOME FAMILIES: Rural areas possess a higher share of non Medicaid, low income families compared to urban areas. Therefore, rural areas would likely receive proportionately more benefits from the low income vouchers.

- OLDER FAMILIES: Proposed cuts in Medicare under S 1770 are financed in part by increasing premiums for higher income seniors and by increasing a range of co-payments retirees in combination with reduction in reimbursement rates for providers. The increases in co-payments and reduction in reimbursements will impact rural areas more, however the increase in premiums for higher income retirees will impact urban areas more based on analysis of RUPRI Poll data (1994).

- FAMILIES PRESENTLY RECEIVING SUPERIOR HEALTH BENEFITS: The RUPRI Panel concludes the net impact of implementing upper limits on tax deductibility falls more on urban areas than rural areas.

CONCERNS:

- S 1770 requires savings in Medicare spending to finance subsidies for low income programs. This means the rural-urban difference in senior citizen populations may become a key rural-urban differential. If the proposed cuts in Medicare represent a real cut in health spending on behalf of seniors, then S 1770 would cause health expenditures in rural areas to rise more slowly than in urban areas.

- Will the 20 percent penalty on individual mandates be sufficient to encourage individuals to purchase and maintain insurance?

- A concern with S 1770 is that families who are health and choose to be uninsured will be forced to purchase insurance. On the other hand, all individuals are responsible for paying for health care and there would be fewer free riders than under the present system.

Local government may be pulled in two directions as a result. They may be looked to as a source to make up hospital revenue shortfall in the short run. This could increase net budgetary impact for rural local government. On the other hand, they could be looked to for leadership in accessing funds for restructuring rural health systems.

The short-term losses to rural hospitals could be offset by aggressive community participation in new programs. The result may be significant restructuring of rural health systems where hospitals assume less prominent roles. The success of this scenario is dependent upon Congressional appropriation of the significant funding levels foreseen by S 1770.

If Congress does not appropriate sufficient new funds, S 1770 could mean measurable decline in rural hospital revenues and greater pressure on local governments to make up the shortfall. In this case S 1770 would exert a net increase in rural local government budgetary load.

6. Other Major Health Service Obligations: There appears to be nothing in S 1770 that would significantly affect local government obligations in areas such as public health and mental health, or other programs.

CONCERN:

1. S 1770 could launch a significant restructuring of the rural health care delivery system. It appears that the restructuring will shift the focus away from rural hospitals--especially those that are financially weak. If funds for new programs that will offset short-run impacts of hospital reimbursement reductions are not appropriated in out-years, pressure for increased local public subsidy of affected hospitals will almost certainly increase. Local govemment officials must be able to see that revenue declines that threaten the economic survival of their hospitals will be offset by programs that will strengthen the overall ability of the rural health system to provided needed services.

II. **Will potential fiscal burdens resulting from health reform fall on rural local governments relative to urban local governments to a greater, lesser, or inconsequential degree?**

EXPERT PANEL CONSENSUS: RURAL AREAS ARE MORE SUBJECT TO CHANGES (NEGATIVE AND POSITIVE) IN FISCAL BURDEN.

RATIONALE:

Rural America has a large proportion of local governments. Most of them are small. Answers to Question 1 imply that small governmental entities are more vulnerable to increased fiscal burdens that may result from any of the health reform measures proposed here.

The 1987 census of governments revealed that the overwhelming number of local governments are located in non-metropolitan areas. When Table 1 is compared with Table 2, we may infer that many rural county, municipal, and township governments serve relatively low-population districts.

The Kansas League of Municipalities has surveyed all municipalities in Kansas. 324 municipalities responded. 289 (89.2%) had less than 75 full-time employees. 285 (88%) had less than 75 full-time employees and less than 6,500 population. The overwhelming proportion of these municipalities were located in non-metropolitan counties.

The Kansas study also found that 95 (29%) responding municipalities did not provide health insurance to their employees. 94 of these municipalities served populations of less than 1000 people. All 95 municipalities employed 9 or fewer full-time employees. Again, municipalities not offering health coverage are overwhelmingly non-metropolitan.

The RUPRI Panel expects that studies similar to the Kansas municipalities study would reveal similar patterns of coverage, rurality, and size of governmental units. In this respect, rural local governments are potentially more vulnerable than their urban counterparts to changes brought about by health reform. Certainly, rural governments should be relatively more advantaged than their urban counterparts by measures that aid small local governments.

TABLE 1: Local Governments and Public School Systems Inside and Outside Metropolitan Statistical Areas, 1987

Gov't. Type	County	Municipal	Township	School District	Special District	Total
Outside MSAs	2,307	11,712	11,655	8,746	16,842	51,262
Inside MSAs	3,042	19,200	16,691	14,721	29,532	83,186

Source: U.S. Bureau of the Census, Census of Governments: 1987.

TABLE 2: County, Municipal, and Township Governments, 1987

Population	# County Gov'ts.	# Municipal Gov'ts.	# Township Gov'ts.
250,000 or more	167	61	4
100,000 to 249,000	231	122	29
50,000 to 99,999	387	285	74
25,000 to 49,999	616	581	233
10,000 to 24,999	943	1,303	706
5,000 to 9,999	698[1]	1,544	1,005
2,500 to 4,999	(NA)	2,151	1,775
1,000 to 2,499	(NA)	3,804	3,722
Less than 1,000	(NA)	9,369	9,143
Total #	3,042	19,200	16,691

[1] For population-size group less than 9,999. (NA) = Not Available
Source: U.S. of the Census, Census of Governments: 1987, vol. 1, No. 1, Government Organizations.

MEMBERS
RUPRI RURAL HEALTH REFORM ECONOMICS EXPERT PANEL

J. Bruce Bullock, Ph.D. is Professor of Agricultural Economics at the University of Missouri and Chair of the RUPRI Board of Directors. He recently completed six years as Associate Director of the Missouri Agricultural Experiment Station and Associate Dean of the College of Agriculture, University of Missouri. Dr. Bullock has published extensively on agricultural and rural policy issues. He serves as moderator of the RUPRI Rural Health Reform Economics Expert Panel.

Sam Cordes, Ph.D. is Head of the Department of Agricultural Economics and Director of the Center for Rural Community Revitalization and Development at the University of Nebraska-Lincoln. He is a past member of the National Advisory Committee on Rural Health, U.S. Department of Health and Human Services and a member of the National Research Initiative Advisory Committee, U.S. Department of Agriculture. He has published extensively on the economics of rural health care, and served as President of the American Rural Health Association.

Gerald Doeksen, Ph.D., is Regents Professor and Extension Economist in the Dept. of Agricultural Economics at Oklahoma State University. He conducts research and provides extension programming on a variety of community service delivery problems. His work on health care issues includes research on the economic impacts of hospitals in rural communities, the development of rural emergency medical systems and rural mental health care, and community health care planning. Dr. Doeksen has received numerous professional awards, including the Research Award of the American Rural Health Association and the Distinguished Extension Program Award of the American Agricultural Economics Association.

Mark A. Edelman, Ph.D. is Professor of Economics and Public Policy, Iowa State University. He is ISU Campus Coordinator for RUPRI, and has directed numerous research projects analyzing rural impacts of public policy issues, including the recently released RUPRI Poll on National Health Care Reform Policy Preferences conducted by the Gallup Organization. Dr. Edelman serves as Coordinator of the Iowa Public Policy Education Project (PPEP), a nonpartisan, issue-oriented citizen education project that produces statewide satellite and TV broadcasts and conducts citizen surveys on public issues. He also serves as a consultant on several state health care reform studies.

David Holland, Ph.D., is Professor of Agricultural Economics at Washington State University. He has over twenty years of research, teaching and consulting experience dealing with the use of multi-sector models for economic impact analysis. Dr. Holland's current work focuses on economic development planning and policy analysis. His Social Accounting Model permits alternative development strategies to be evaluated in terms of their impact on employment and the distribution of income.

Thomas G. Johnson, Ph.D., is Professor of Agricultural Economics Virginia Polytechnic & State University. Dr. Johnson has extensive research, teaching and consulting experience in regional economics and rural community economic development. He has received numerous professional awards, and is a past President of the Southern Regional Sciences Association. Dr. Johnson works closely with community leaders in Virginia and other states to estimate the future economic and fiscal impacts of various community policy proposals. His health care related research includes analysis of the economic impacts of rural community hospitals.

Timothy D. McBride, Ph.D., is Assistant Professor of Economics, Public Policy and Gerontology at the University of Missouri - St. Louis. Dr. McBride's research concerns public economics, with special emphasis on the economics of aging and health. He is the author of over a dozen research articles and co-author of a book, titled *The Needs of the Elderly in the 21st Century*. In the health policy area, Dr. McBride's research has focused on the uninsured, long-term care, and health care reform. Dr. McBride joined the Department of Economics in 1991 at the University of Missouri-St. Louis after spending four years at the Urban Institute in Washington, D.C. He received his Ph.D. from the University of Wisconsin in 1987.

Shirley L. Porterfield, Ph.D. is Visiting Assistant Professor, in the Dept. of Political Science, Washington University in St. Louis. Dr. Porterfield has published numerous research articles on regional development issues, with particular emphasis on the impacts of industrial restructuring on employment, earnings, and fringe benefits. She is currently working on an analysis of workers and industries adversely impacted by implementation of the North American Fee Trade Agreement. Dr. Porterfield began her career at the Economic Research Service, US Department of Agriculture. She recently joined the faculty at Washington University after spending two and a half years at the Rural Policy Research Institute at the University of Missouri-Columbia. She received her Ph.D. from the University of Wisconsin in 1988.

Ron Young, Ph.D. is the Kansas State Cooperative Extension Local Government and Rural Health Economist. Dr. Young has served Wisconsin state government as a team leader for program development and evaluation in the Division of Health and Social Services. He has also worked as the manager of data analysis for the CNA Insurance Companies. Dr. Young is currently participating in several state and national health policy and health economics-related initiatives. He is Director of the U.S. Cooperative Extension System's "Health Care Reform Education Development Project", serves as a member of the Kansas State Health Data Consumer Task Force, and is Associate Director of the evaluation project for the state's Senior Care Act. Dr. Young also directs an ongoing multi-country analysis of the economic impacts of rural hospitals.

CRITICAL COMPONENT IV: RURAL LOCAL GOVERNMENTS

A simple analytical approach has been adopted to address the economic consequences of health care reform for rural local government--county and municipal. For each area of potential impact, the RUPRI panel anticipates the fiscal/economic impacts for government to be characterized by one of three conditions: 1) no change; 2) greater net fiscal demands on government; 3) smaller net fiscal demands on government.

In terms of a general evaluation of anticipated net demands on government as a result of health care reform, we expect the "no change" possibility to be very unlikely. Local government will be actively involved in dealing with health care reform implementation and its consequences. It would be surprising if all the possible effects on government financial responsibilities netted out to zero.

An evaluation of the impact of health reform on local governments must take into consideration both the change in government expenditures for health related items and the change in revenues to governments resulting from health reform measures. Ideally, from a government point of view, reform would be most beneficial if it reduced government expenditure on health care items while effecting economic changes in the overall economy that promoted expansion of the tax base. Conversely, reform measures that increase local government fiscal load while shrinking tax base would likely be less welcome by government officials.

Any health reform measure will likely affect local government in one or all of three major areas of responsibility. 1) As an employer: local government expends money for employee health insurance and for contributions to the Medicare Hospital Insurance Trust. 2) As a purchaser/provider of health care services: local governments often own or subsidize hospitals, emergency medical systems, public health facilities and operations, as well as a range of other health care services (e.g. mental health). 3) As a revenue/tax collector: local government collections will be influenced by the way health reform affects their main revenue sources (e.g. property values, personal/family income, business activity, user fees).

In the following analysis, the net effects of reform will be assessed for each of the three main areas of local government responsibility identified above.

I. **Compared to a continuation of current trends, will the fiscal burden on rural local governments be increased, decreased, or left unchanged if the bill is enacted as introduced?**

HR 3600 HEALTH SECURITY ACT

EXPERT PANEL CONSENSUS: IN THE LONG RUN, THE FISCAL BURDEN ON RURAL LOCAL GOVERNMENTS, IN THEIR ROLE AS EMPLOYER, WILL BE UNCHANGED. IN THE SHORT RUN THE FISCAL BURDEN ON SOME LOCAL GOVERNMENTS MAY INCREASE.

RATIONALE:

1. In their role as employers, the behavior of local governments in their role as employers should resemble that of non-health businesses (see Panel analysis of "Impacts on Rural Non-Health Business,). In the short run, small local governments that offer no health coverage or limited health coverage should experience pressure finding funds to cover the employer share for health premiums (See Lewin for a discussion of the nature of the potential to all governments--rural and urban). Over time, as with business, governments should pass the cost of coverage through to their employees. Indeed, the pass-through may occur more rapidly than in the private sector, if tax payers resist additional levies to pay for increased public employee coverage. Further, the pass-through of the employer share to employees in the public sector should more closely approach 100%.

2. HR 3600 will require all local governments to contribute to the Medicare Hospital Insurance Trust. For those governmental entities not currently making contributions, this requirement will mean increased net burden on government budgets, in the short run. Over time, these contributions should be passed on to employees, as well.

CONCERNS:

1. If governments are not able to fully pass the cost of health reform to public employees, they will be faced with the problem of finding funds to meet the employer share. If increased economic activity is insufficient to raise revenues under prevailing tax rates, rural local governments will be forced to decide among the fiscal choices of raising taxes, cutting other services, or reducing employment. The local governments facing such a choice are most likely to be smaller and more fiscally stressed, of which most are in rural areas.

2. It is likely that more fiscally stressed governments will not be eligible for employer subsidies (Lewin, p. 64). Where fiscally stressed local governments cannot pass 100% of the employer premium share to employees, the fiscal choices noted in the previous point could lead to more difficult decision-making circumstances for local public officials.

EXPERT PANEL CONSENSUS: INCREASES IN REVENUES AND TAX COLLECTIONS WILL REDUCE THE FISCAL BURDEN ON RURAL LOCAL GOVERNMENTS.

RATIONALE:

1. In general, county governments, school districts, and special districts rely primarily on property taxes for tax revenues. There is some reliance on sales

taxes, excise taxes (cigarettes, etc.), user fees, and to a lesser extent income taxes. Municipal governments tend to place a greater proportional reliance on sales and income taxes in their revenue mix.

2. Many of the taxes (new and adjusted) arising out of HR 3600 will initially bypass local govemments. Such tax monies may return to states in the form of payments for health services and coverage, as grants, or as subsidies of some kind. Local tax revenues are generally linked to secondary effects within the economy.

3. Economic activities in rural areas should not be adversely affected. Although households will spend more on health care coverage, the amount should be more than offset by out-of-pocket and other direct health-related costs to households (see Lewin, p. 80, and the "Household Impact" section. This should mean stable to slightly increased sales and income tax base. Business activity, especially in the agricultural sector, should remain stable. When coupled with household income, stable business activity will not depress property values. Property values could rise, increasing the tax base.

EXPERT PANEL CONSENSUS: WHERE LOCAL GOVERNMENTS OWN OR SUBSIDIZE A HOSPITAL, THE FISCAL BURDEN SHOULD REMAIN UNCHANGED OR POSSIBLY DECREASE SLIGHTLY.

RATIONALE:

1. The loss of Medicare/Medicaid disproportionate (DSH) share payments and other reimbursement reductions to hospitals could reduce revenues to hospitals, especially in poorer rural areas (see Lewin, p. 61, for a discussion of the impact on local governments in general). For those rural counties and municipalities having high population proportions of low-income Medicare eligible people, it is anticipated that this will lead to increased fiscal pressure on local government. The RUPRI Panel expects these impacts to be effectively offset.

2. Hospital Net Effects: Medicare savings realized through reductions in the rate of growth in reimbursements to hospitals (DSH and others) are expected to be redirected to other forms of health care expenditures (e.g. subsidies to low-income families). The health care business section of this analysis anticipates an expansion of overall business activity in the rural health sector. A proportion of these monies will return as hospital reimbursements.

   Reduced reimbursements to rural hospitals should be offset by at least four countervailing developments under HR 3600: (1) the redirection of Medicare savings to the hospital expenditures of other populations; (2) the new "vulnerable populations" entitlement program--$800 million. This program will be similar to Medicare and Medicaid DSH programs (CRS p. 104). For those

hospitals participating, some of the losses under DSH reductions should be offset; (3) grants and programs to encourage reorganization of rural primary care systems; (4) expanded economic activity in the rural health sector.

3. Other Major Health Service Obligations (Mental Health/Public Health Screening): Increased coverage for mental health should reduce expenditures at local levels.

   Public Health expenditures at the state level are expected to rise (see Lewin). No significant change is anticipated at the local government level. Emphasis on expanded public health programs should tend to relieve local government budget burden.

CONCERN:

1. The timing and sequence of program impacts on rural hospitals, especially the development of replacement revenue streams, are of critical importance. Hospital expenditures (along with public and mental health) are generally the largest health-related service obligations for those rural local governments with a facility in their district. If rural hospitals experience revenue declines from DSH and other reimbursement adjustments before they see the offsetting effects of other health spending features of HR 3600, there could be pressure for local governments to make up the shortfall in the short run.

   For large numbers of rural hospitals DSH reductions are not significant. Of greater importance is the "Medicare Dependence" payment program. Although HR 3600 makes no provisions to change this program, it is important that the potential fiscal effects of changing Medicare dependence and other programs supporting rural health systems be taken into consideration as health reform proceeds in future years.

HR 3222 THE MANAGED COMPETITION ACT OF 1993

EXPERT PANEL CONSENSUS: THE RUPRI PANEL DOES NOT ANTICIPATE SIGNIFICANT ADDITIONAL NET BUDGETARY BURDEN ON RURAL LOCAL GOVERNMENTS IN THEIR ROLE AS EMPLOYER.

RATIONALE:

1. Local governments are not required to contribute to employee health insurance premium costs. The bill does require employers to make insurance available to those employees who wish to purchase coverage. In aggregate, the additional administrative cost of making coverage available to those employees currently uninsured should be offset by savings to governments currently covering their employees. Most rural local governments currently

providing health insurance are not large groups, and should benefit from community rating, thus reducing the net budgetary burden of coverage.

EXPERT PANEL CONSENSUS: THE FLOW OF TAX DOLLARS WILL NOT SIGNIFICANTLY AFFECT THE FISCAL CAPACITY OF RURAL LOCAL GOVERNMENTS.

RATIONALE:

1. Many of the taxes (new and adjusted) arising out of HR 3222 will initially bypass local govemments. Such tax monies may return to states in the form of payments for health services and coverage, as grants, or as subsidies of some kind.

2. The RUPRI Panel analysis of family income effects and net business activity resulting from HR 3222 measures has detected no trends that should significantly current trends in rural collections of property taxes, sales taxes, or income taxes.

3. Federal and State Aid/Transfers: Local governments may anticipate very slight, to no increases in health-related grants and aid from state and federal sources. Most of the money should be earmarked for rural health systems planning and development. The offsetting effects for rural hospitals should be minimal.

EXPERT PANEL CONSENSUS: THE FISCAL BURDEN ON LOCAL GOVERNMENT FROM CHANGES IN HOSPITAL REIMBURSEMENTS ARE UNCERTAIN.

RATIONALE:

1. Medicaid Hospital Disproportionate Share Elimination (DSH): Medicaid would be repealed. The bill introduces a new federal subsidy for the payment of acute care coverage premiums for low-income families.

   Effects on local governments may vary significantly by region. Where rural health systems serve many Medicaid patients, there will be increased pressure on local government to make up short-falls associated with the loss of the DSH portion of hospital reimbursement for low-income patients. Where there are no health services or small Medicaid eligible populations, the change at local level should not be significant.

2. Medicare: Medicare payments would be reduced for hospitals. There would be a phased in elimination of Medicare Hospital Disproportionate Share adjustment payments. For those rural counties and municipalities having high population proportions of low-income Medicare eligible people, it is anticipated

that this will lead to increased load on local government.

3. Disproportionate Share Compensation: Several programs would be established for hospitals serving vulnerable and underserved populations. The program dollars can also be used for non-hospital health system development. They are targeted to both rural and urban areas. The total amount authorized for all such programs is $230 million.

4. Hospital Net Effects: Reduced reimbursements to rural hospitals should not be offset by new program expenditures for which rural hospitals may be eligible. Reductions in program reimbursements that can affect rural hospitals (especially those which have diversified their services) are (1) reduction in update for inpatient hospital services; (2) reduction in hospital out-patient services through establishment of prospective payment system; (3) reduction in routine cost limits for home health services; (4) reduction in routine cost limits for extended care services; (5) reductions in payments for hospice services. In this regard, for those local governments with hospital subsidy obligations, additional net burdens may be anticipated.

5. Public Health/Screening: Federal expansion of public health programs should tend to relieve local government budget burden.

CONCERN:

1. As reform falls further from universal coverage, offsetting programs will have less impact in making up reimbursement losses to rural hospitals. If rural communities do not see structural improvements in their overall health system, they are likely to pressure their government officials to make up any shortfall, thereby increasing fiscal burden.

S 1770 HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993

EXPERT PANEL CONSENSUS: NO SIGNIFICANT ADDITIONAL NET BUDGETARY BURDEN IS ANTICIPATED ON RURAL LOCAL GOVERNMENTS, IN THEIR ROLE AS EMPLOYER.

RATIONALE:

1. Employee Insurance: As an individual mandate bill, S. 1770 does not require local governments to contribute to employee health insurance premium costs. It does require employers to make insurance available to those employees who wish to purchase coverage. Small employers will either join a purchasing cooperative or offer a standard plan through a health plan. Large employers (over 100 employees) can offer a standard package and can form their own purchasing pools. Employers will be required to act as a fiduciary

intermediary (i.e. they will collect premium from employees and transfer to the chosen health plan). In aggregate, the additional administrative cost of making coverage available to those employees currently uninsured should be offset by savings to governments currently covering their employees. Most rural local governments already providing health coverage are not large groups and should benefit from community rating, thus reducing the net fiscal burden of coverage.

EXPERT PANEL CONSENSUS: RURAL LOCAL GOVERNMENT REVENUE AND TAX COLLECTION WILL NOT BE SIGNIFICANTLY AFFECTED.

RATIONALE:

1. Income Tax:

   Individual: Personal/household income should not be significantly impacted. The marginal effects should change income tax collections only slightly, if at all.

   Corporate: Corporate profits should not be affected, and thus this revenue source should not be affected.

2. Sales Tax: No change or only slight declines in sales tax collections are anticipated.

3. Property Tax: No change in property values are anticipated. Rural local governments should not anticipate reductions in property tax base and collections.

4. Federal and State Aid/Transfers: Local governments that aggressively pursue funding under new health systems development programs could anticipate moderate increases in health-related grants, and aid from state and federal sources. Most of the money should be earmarked for rural health systems planning and development.

EXPERT PANEL CONSENSUS: THE CHANGE IN FISCAL BURDEN FOR RURAL LOCAL GOVERNMENT IN THEIR ROLE AS PROVIDER/PURCHASER OF HEALTH SERVICES IS UNCERTAIN.

RATIONALE:

1. For many rural local governments which own or subsidize a hospital, the largest single line in the annual budget may be the hospital. Reform measures which depress hospital reimbursements without providing offsetting revenue generating programs could increase the net budgetary burden for local

governments if they choose to make up additional shortfalls with public money.

2. The Medicaid features of S 1770 are complex. It appears that little net impact on local health systems would result. Since the bill requires a gradual phase-out of DSH, the immediate impact of that feature should be ameliorated. The gradual nature of the phase-out should allow affected institutions to make some adjustments.

   Effects on local governments may vary significantly by region. Where rural health systems serve many Medicaid patients, there will be increased pressure on local government to make up short-falls associated with the loss of the DSH portion of hospital reimbursement for low-income patients. Where there are no health services or small Medicaid eligible populations, the change at local level should not be significant.

3. Medicare payments would be reduced for hospitals. There would be an elimination of Medicare Hospital Disproportionate Share adjustment payments, reduced payments for outpatient hospitals could be significant for rural hospitals, as many have shifted services from inpatient to outpatient, eliminate payments to hospitals for enrollees bad debt, impose cost-sharing on lab and home health services. For those rural counties and municipalities having high population proportions of low-income Medicare eligible people, it is anticipated that this will lead to increased load on local government. The range of hospital-oriented payment reductions should affect all hospitals with Medicare patient load. This could mean that rural hospitals will be confronted with new shortfalls and will look to their local governments for relief.

4. S 1770 does not offer programs that directly offset hospital reimbursement reductions. Instead, it introduces and strengthens programs designed to restructure primary care service delivery. It offers (1) grants to community-based primary care entities; (2) grants for Federally Qualified Health Centers (FQHC); (3) grants for rural health networks; (4) Rural Emergency Access Care Hospitals; (5) grants for air transport systems.

   The proposed funding for these programs is quite large: > $5 billion over 4 years. Not all funds are earmarked for rural areas, but the amounts are significant. The initial losses to hospitals from reductions in existing programs could be substantially offset if rural providers and administrators successfully access the new funds provided by the bill.

5. Hospital Net Effects: Reduced reimbursements to rural hospitals will not be directly offset by new program expenditures for which rural hospitals may be eligible. Reductions in hospital reimbursements may be regained by affected communities if they participate in new programs intended to restructure rural primary care delivery.

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